"THE FORGOTTEN CONSTITUENTS"

A REPORT BY THE
TASK FORCE COMMITTEE
ON THE
MENTAL HEALTH SERVICES IN SASKATCHEWAN
MAY, 1983

MENTAL HEALTH ASSOCIATION IN SASKATCHEWAN

A REPORT

ON

"THE FORGOTTEN CONSTITUENTS"

TO

THE MENTAL HEALTH ASSOCIATION IN SASKATCHEWAN

by

THE TASK FORCE COMMITTEE

ON THE MENTAL HEALTH SERVICES IN SASKATCHEWAN

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Dean Elect of the Faculty of Medicine,

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and Chairman of the Task Force Committee on

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for the magnitude of his effort and contribution

to the development and completion of

this outstanding document

and to members of the Committee

for their substantial assistance

in preparation of

"THE FORGOTTEN CONSTITUENTS"

May, 1983

The Board of Directors
Mental Health Association in Saskatchewan

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I TERMS OF REFERENCE

In May, 1980, the Mental Health Association of Saskatchewan established a Task Force to look into mental health issues in the province. This Task Force was to consist of 16 individuals representing a cross section of Saskatchewan. Dr. I. M. McDonald, Professor of Psychiatry, University of Saskatchewan, was appointed Chairman of the Task Force.

The Task Force was asked to examine:

1. Existing programmes and services in the field of mental health.

2. How our province could provide the best possible treatment and rehabilitation services to people with emotional and psychiatric problems.

3. How Saskatchewan people could best be equipped with skills and abilities that will help them to effectively cope with problems, tension and anxiety in their lives.

4. How our province's social environment could be improved and ways that would help to promote mental well being. (In this sense our social environment would include such things as our schools, work-places, rural and urban communities and families as well as the status of children, women, the elderly and native people.)

5. How Saskatchewan's physical environment could be improved and ways which would help promote mental health. (In this sense, the physical environment would include such things as our air, water, food and soil as well as such things as substances used in the workplace, on the farm and in the home.)

II OVERVIEW

In May, 1980, the Mental Health Association in Saskatchewan in response to concerns about the quality of mental health services in the province, established a Task Force to look at current and future needs of mental health programming.

The Association appointed a sixteen person Task Force Committee representing a cross section of the province. It included professionals and non-professionals, men and women, and representatives of both urban and rural regions. The Task Force Committee was given Terms of Reference (Chap. I) relating to the identification of current programmes, current needs and recommendations for the future.

This did not constitute the first review of mental health services in Saskatchewan. It would be surprising if any other area of government activity has been the subject of as many enquiries and reviews as has the Psychiatric Services Branch. The Mental Health Association was aware that over the previous fifteen years there had been a number of such reviews, the most publicized being the Frazier Report of 1968. In deciding to establish yet another review, the Association was not questioning either the validity or the adequacy of previous studies. What it was suggesting was the need for action. Many of the previous reports, including that of Dr. Frazier's, contained important as well as practical recommendations, most of which were not enacted. It was hoped that a public survey conducted by a citizens' organization might prove more effective.

METHODOLOGY:

The Mental Health Association in Saskatchewan possessed limited resources both in terms of manpower and finances. This restricted the nature and extent of the enquiry of the Task Force. The absence of a full-time secretariat and/or research staff limited the capability of the Task Force to conduct its own independent research. The Committee had to rely to a large extent on the

co-operation of professionals, organizations and the public at large in providing information with respect to the adequacy of existing programmes and the identification of future needs.

In order to canvass as large a sample of opinions as possible, the Task Force developed the following strategy:

1. Advertisements were placed in weekly and daily newspapers throughout the province announcing the establishment of the Task Force and its Terms of Reference. Submissions or briefs from the general public and professional organizations were requested.

2. A mail canvass of some 600 groups, agencies and individuals identified as working in fields related to mental health was conducted. The Terms of Reference were outlined and submissions were requested.

3. The Task Force established five Working Groups in order to examine health issues relating to certain target populations: Children & Youth, The Elderly, Adults, Citizens of Indian Ancestry and Women. The Working Groups consisted of Task Force Members, supplemented by resource people from the community with special expertise in these areas. The Working Groups developed position papers addressing the Terms of Reference as they related to their target population.

4. The position papers from the Working Groups were circulated to a select number of individuals and organizations for reaction.

5. Using the position papers of these Working Groups and the reactions to them, the Task Force developed an Interim Report in which it summarized the findings and made 70 recommendations.

6. The Interim Report was sent to all individuals and groups who had made submissions to the Task Force as well as to a number who had not. All were asked for comments on the Interim Report and its recommendations.

7. The Interim Report was presented at the Annual Meeting of Mental Health/ Saskatchewan held in Yorkton on May 30, 1981. A full day workshop was devoted to discussing the findings and recommendations.

8. In September and October, 1981, public hearings were held in Prince Albert, North Battleford, Regina and Saskatoon. On these occasions additional submissions were received from a variety of individuals and groups.

Following completion of the above surveys, the Task Force then prepared its Final Report.

The Task Force acknowledges the limitations of a survey such as this. It recognizes that it may be exposed to a number of criticisms. It regretted that it was unable to visit all mental health regions so that it could meet with mental health professionals, agencies and the public. The Task Force Committee also recognizes that it could be criticized for being unduly dependent on external sources of information. Certainly it would have been preferable to have been able to base its findings and recommendations on independent research and investigation conducted under its own auspices. Finally, the Task Force recognizes that the public response to its enquiry would in all likelihood have been greater if a more intensive and extensive advertising campaign had been conducted. Unfortunately as mentioned, financial constraints prevented this.

The Task Force was reliant upon the interest and co-operation of the media in getting its message across to the public. It wishes to acknowledge its indebtedness to the newspapers, radio and television stations of this province for the publicity given to our various reports, news releases and the public hearings. It is also indebted to the media for its continuing interest in mental health issues.

In spite of the obstacles noted above, the Task Force was successful in soliciting some 85 briefs and a total of 167 submissions. It was successful in attracting representations from all parts of the province and from a cross section of the population. Submissions were received from rural and urban groups, natives and non-natives, women's groups, professional and lay organizations, government and non-governmental agencies. These submissions ranged from letters from private citizens to extensively researched and well documented briefs from professional organizations.

It was the intent of the Task Froce to take a broad look at MENTAL HEALTH. At the outset it had hoped that it would be able to get beyond the questions of prevalence of mental illness and the adequacy of mental health services and address those issues relating to the quality of life in the home, the

community and the workplace of all people in Saskatchewan. As our survey developed, however, it appeared that this did not strike a responsive chord with the public. Responses received indicated little interest or concern about environmental or work related problems. The majority of briefs and submissions were concerned with here and now issues of mental health services. Inasmuch as this report attempts to reflect concerns identified by the public, it may be considered to be deficient in its treatment of the fifth and final Term of Reference.

Surveys such as this have to be approached with a certain degree of caution. Submissions are more likely to be received from individuals and groups who have complaints rather than from those who are satisfied with the system. This certainly was the case in this instance. Having said that, however, the recurring themes of many submissions were so consistent with those of previous reports, in particular the Frazier Report of 1968, that we felt confident that they contained considerab substance.

Our survey was unsuccessful in eliciting significant response from certain sectors of the community; e.g. employers, employees (and unions) and certain professional groups (teachers). There was also a disappointingly small number of submissions received from patients and relatives. This fact was at variance with information received from a number of sources including government officials of increasing public disquiet about existing mental health programmes. Those who made submissions either through letters or the public hearings, provided the Task Force with revealing and helpful insights into the impact of our services on their consumers. Their contributions were invaluable.

The lack of consumer response represents one of the major obstacles to effecting changes in our service programmes. Because of the stigma which still exists in the minds of many about mental illness, patients and relatives are diffident - understandably - about coming forward. Unfortunately this lack of assertiveness is too often interpreted by government as meaning satisfaction with, or at least acceptance of, the status quo. In the absence of any information to the contrary, the public may be indifferent or apathetic

about issues affecting hundreds, indeed thousands, of their fellow citizens. Increasingly governments appear to be taking the lead from the public rather than vice versa, so that in the absence of increased public awareness the prospect for change will be slight. This suggests the need for enquiries such as this.

By far, the largest majority of submissions came from those working in the mental health field. Whether involved in non-governmental activities (e.g. approved home operators) or as members of government service programmes (e.g. psychologists, psychiatrists, social workers, RPN's), these submissions were of particular help to the Task Force. We are especially grateful to those who took trouble to write or to appear at the public hearings. Their frankness and candor in discussing the Interim Report's recommendations was helpful and appreciated.

FINDINGS:

Saskatchewan has enjoyed an international reputation of being in the forefront of mental health programming. In Canada it led the way in mental hospital reform, starting with the open-door policy right through to deinstitutionalization and the regionalization of mental health services. It introduced a new mental health professional in the form of the Registered Psychiatric Nurse. It transformed a province with the highest ratio of its population institutionalized to one which now has one of the lowest bed ratios on the continent. It has attracted and trained a body of mental health professionals of great dedication and skill. The quality of these professionals is attested to by the fact that so many have been recruited to fill senior positions in programmes across Canada and the United States. Yet in all the submissions there was a recurring theme that the province no longer is providing the leadership it once did. This came not only from the users of the service but especially from those providing them. There was an overall feeling of disappointment, frustration and pessimism among mental health workers. The pessimism expanded to include the Task Force enquiry itself. Many workers, aware of previous reviews and past hopes for change, have also

seen these hopes dashed by an apparent lack of responsiveness on the part of government. It was obvious to us that the morale of people working in the mental health field is a major issue in this province today.

In reviewing the existing service system in Saskatchewan, the Task Force notes that the so-called Saskatchewan Plan of regionalization of services has been partially achieved. Two major mental hospitals have been successfully phased out and replaced with small regional hospitals and psychiatric wards. Yet the second stage of the regionalization of services; namely, the establishment of a full range of community programmes has not yet been attained. There remain serious gaps in this system which are causing increasing pressures on inpatient programmes and the community.

The manpower problem first identified by Frazier in 1968, remains unsolved. While there have been some gains made in total numbers of psychologists and social workers, there are chronic difficulties in the recruitment and retention of well trained staff. This is particularly notable with respect to psychiatrists. The shortage of this professional group has reached crisis proportions. The Task Force notes that some of the problems in retaining qualified staff relates to dissatisfaction with the conditions of employment in government service. Well trained professionals are one of our greatest natural resources and must be preserved. The Task Force recommends ways of achieving this.

Our survey identified a universal concern about the adequacy of community support services for both patients and their families. From all sectors of the community and from all parts of the province, criticisms were voiced about the inadequate supply of appropriate residential settings, vocational rehabilitation and socialization programmes.

Particular concern was expressed about the so-called "hard-to-manage" patients. This small group of patients are not well served by existing programmes. They are shunted from one human resource agency to another at great expense in time and energy to families, professionals, the community

and indeed to themselves. The problem is not new and has been known to mental health workers for some years. Faced with inadequate funding and staffing, they have had to resort to trying to fit this group into existing programmes without success. The Task Force does not feel that this failure warrants re-opening of the large mental hospitals. To the contrary, it indicates the need for the government to give a high priority to the development of a wide range of community residential settings, accommodating varying levels of supervised care.

Although it has now been almost twenty years since the beginning of the move from the institution to community-based programmes, there is no evidence that programmes are yet in place in sufficient quantities to meet the growing needs of the community. This lack was first identified by Frazier in his report of 1968. The response of successive governments to his recommendations has been inadequate. It is in this area of community services that Saskatchewan has fallen behind other provinces and other jurisdictions in North America. Our programmes are both inadequate and unimaginative. The Task Force recommends that a high priority be given to developing a full range of community services.

The Task Force identified particular deficiencies in mental health services for the elderly, the young and citizens of Indian ancestry. In many areas these services are non-existent or grossly underdeveloped. In addition to these deficiencies, we note the continuing disparity in the level of services available in rural vs. urban regions. Finally, the report identifies special needs of the mentally retarded and the hearing impaired.

The Task Force notes that all governments across Canada have seized upon primary prevention as the solution to the spiraling costs of health care. This was the case in Saskatchewan at the time of our survey. Our review, however, fails to reveal any signficant effective preventive strategy in the programmes of the provincial government. There is no evidence of an effective and proven overall preventive programme nor, indeed, any evidence of future financial commitments on the part of government. Although the Task Force agrees that more attention should be paid to developing primary preventive

strategies, it concluded that primary prevention in the area of mental health has not developed to the point where we can safely relegate secondary and tertiary preventive measures to second and third position. The implementation of any major primary preventive programme, therefore, is going to require significant increase in financial and manpower resources. We conclude that it would be impossible to embark on such initiatives within the existing programmes without seriously affecting those services that are currently provided. The Task Force concludes, therefore, that the government should demonstrate its good faith by ensuring additional funds to implement a few pilot primary preventive programmes with a commitment to gradual growth of these programmes over the next few years if they are found to be effective.

It is recognized that one of the major obstacles facing mental health programmes is the stigma associated with mental illness, yet the Task Force could find no evidence of a concerted attack on this problem through any significant public education programme. Although the government through its Department of Health and other agencies has mounted well publicized programmes (e.g. "AWARE", "FEELIN' GOOD"), public education regarding mental health issues has been notable by its absence.

The Task Force notes that one of the few bright spots in the overall picture has been the government's commitment and support in the field of research. Saskatchewan in the past and presently continues to lead in mental health research programmes, thanks to the activities of the Basic and Applied Studies Units in the Research Division of the Psychiatric Services Branch. These units have achieved national and international status as a consequence of the contributions they have made over the past twenty years. The Task Force stresses the need for maintaining a vigorous research arm within the Psychiatric Services Branch.

The Task Force differs from its predecessors, and in particular the Frazier Report, in its emphasis on the need to develop a greater community involvement in mental health planning. The report identifies what we consider to be an undue dependence on government agencies and programmes to meet the

manifold mental health needs of our society. The Task Force felt that there was a large and, as yet, untapped resource in every community that could and should be mobilized to help plan and deliver a wide variety of mental health services at a regional level. In the opinion of the Task Force, both the public and government have not given this sufficient attention. We recommend a major thrust towards the encouragement and development of non-governmental agencies in the mental health field.

A recurring theme throughout this report is the issue of manpower; equally important, however, is the issue of funding. The Task Force points out that mental health programmes in the province of Saskatchewan have been significantly underfunded. Our report shows that whereas government spending and programmes in the Department of Health increased 48% and 46% respectively between 1972-73 and 1981-82, the real increase in funds to the Psychiatric Services Branch actually decreased by 0.1%. These restraints have been implemented at a time when the demand for services increased significantly both in the government and non-government field areas. The Task Force points out furthermore, that the deinstitutionalization policy has resulted in significant savings to the public treasury - at least $50 Million annually - which savings however have not been put back into mental health programming.

Many of the findings of this Task Force indicate that little progress has been made since the Frazier Report of 1968. The fact that there has been so little progress and so little public alarm is distressing and unnerving. The Task Force concludes that the apparent public apathy and indifference is actually a reflection of its lack of knowledge and information about the current status of mental health services. One cannot expect the major service providers (government) to disseminate this information and as our experience revealed, one cannot count on patients or their relatives to come forward. The Task Force identifies, therefore, a need for a strong advocate who will be able to identify the deficiencies and needs in our mental health services and to keep these in front of the public. Unless the public is informed, they will not be concerned and unless the public is concerned we cannot expect political response. Our Task Force recommends, therefore, that the Mental Health Associa-

tion in Saskatchewan establish as its number one priority, its role as advocate for mental health issues. We urge it to become more broadly representative of the Saskatchewan public and to identify and implement actions directed at achieving greater community representation and involvement. When the Association has done this it will truly be able to represent those who urgently require its help.

The Interim Report contained recommendations with respect to the programmes of the Alcoholism Commission of Saskatchewan. These were based on the position paper of the Working Group on Services for Adults. On reflection, the Task Force concluded that while there were indeed mental health aspects to alcoholism (e.g. the association with stress and depression), the mandate of the Alcoholism Commission was much broader. Therefore, the Final Report does not single out this particular "disease" entity for special discussion but instead discusses the services that are available to alcoholics and their families.

RECOMMENDATIONS:

The recommendations of the Task Force are based on the belief:

1. That health is "a state of complete physical, mental and social well-being and not merely the absence of disease".

2. That every individual has the right to expect an environment which promotes health both physically and psychologically.

3. That every person in Saskatchewan must recognize that they have a role to play in the maintenance of their own and everyone else's mental health.

4. That neither stigma nor blame should be attached to those suffering from mental illness.

5. That every person has the right to expect equivalent care, consideration and acceptance regardless whether they are suffering from a physical or mental illness.

6. That a comprehensive mental health programme should direct itself to prevention as well as to treatment and rehabilitation.

7. That a comprehensive mental health system should:

   (a) be sensitive to the changing mental health needs of the population it serves.

   (b) be accessible to all regardless of age, sex, cultural background or place of residence.

   (c) provide appropriate services for the diverse needs of its individual clients.

   (d) be effective and efficient.

   (e) be accountable to the public it serves as well as its funding agencies.

   (f) be conscious of the need for maximum community involvement in the planning and delivery of mental health services.

We recognize that as a result of years of relative financial neglect by a succession of governments the mental health system in Saskatchewan finds itself in a catch-up position. We also recognize the financial realities of the day. Accordingly, the Task Force has priorized seven major recommendations (see Chapter X for a detailed listing of all the recommendations) requiring urgent attention. These are, in order:

1. That mental health services receive immediately a more equitable share of health funds.

2. Urgent attention be given to those measures that will facilitate the recruitment, retention and training of mental health professionals in Saskatchewan.

3. In order to enable more patients to remain in the community, the government should fund the development of a range of residential, rehabilitation and socialization programmes in every mental health region.

4. The government must accept its responsibility to be in the forefront of mental health development through the promotion of innovative and experimental programmes both governmental and non-governmental.

5. The government should insist that all tax-supported programmes establish standards of care and staffing as well as measures of outcome evaluation.

6. That the government recognize the need to promote education, prevention and research as essential components of comprehensive health programmes by funding preventative programmes and by enhancing governmental research programmes.

7. The government should establish mechanisms in every health region to ensure the co-ordination and integration of tax-supported mental health programmes.

CONCLUSION:

The Task Force was dependent on data from a variety of sources and agencies to support its recommendations. This data was collected over a period of two years. Some statistics may not accurately reflect the current state of affairs. We do not feel, however, that the discrepancies will be of such magnitude to invalidate our conclusions and recommendations.

Finally, on a number of issues the Task Froce received a wide range of opinions and recommendations. Some of these conflicts were easier for us to resolve than others (e.g. the need to re-open the mental hospitals). Some were more difficult to resolve even within the Task Force Committee (e.g. primary prevention programmes; counselling programmes for women concerning abortions; etc.). The recommendations in these instances reflect a majority but not the unanimous opinion of the Task Force Committee.

The work of this Task Force Committee was only possible through the unselfish dedication and co-operation of countless numbers of people across this province. We are indebted to these individuals and groups who took the time to write, to prepare briefs, and to present submissions in person at our public hearings. We hope that our recommendations will reflect, to a large degree, their hopes and aspirations for a more responsive and equitable mental health system.

* * * * * * * *

III HISTORY

The history of specialized mental health care in Saskatchewan began in 1914 with the construction of the first provincial mental hospital at North Battleford. Until 1914, those early Saskatchewan settlers who encountered emotional or psychiatric problems had two choices: to fend for themselves as best they could without special care or be sent away to the mental hospital at Brandon, Manitoba.

The establishment of the Saskatchewan Hospital in North Battleford was an early step in the long process of bringing mental health care closer to the people of Saskatchewan. Unfortunately little was known about psychiatric illnesses at the time and treatment methods were rudimentary. While some of the people who entered the hospital recovered quickly and were discharged after a few weeks, many patients ended up staying for months, years, or not infrequently for the rest of their lives. The result was a steady increase in the number of patients. Soon after its opening, the North Battleford hospital began to experience the stresses and strains that are associated with overcrowding. Originally designed to accommodate 378 patients, by June, 1920 - only six years after it opened - it housed 853 patients.[1] In 1921, a second hospital was opened at Weyburn, but numbers continued to mount. By the late 1920's problems of over-crowding were again becoming severe, with 985 patients at Saskatchewan Hospital, North Battleford, and 1,058 at Saskatchewan Hospital, Weyburn.[2]

In 1929, the provincial government invited Dr. Clarence Hincks, Director of the National Committee for Mental Hygiene (forerunner of the Canadian Mental Health Association) to visit Saskatchewan. Together with Dr. Sam Laycock (founder and first President of the Mental Health Association in Saskatchewan) and Dr. O. E. Rothwell, Dr. Hincks was charged with the task of making recommendations to the Anderson Government regarding the future of mental health care in the province.

The 1930 Hincks Report made a number of suggestions, including:

- setting up mental health clinics and psychiatric wards in general hospitals,
- training and employment of more highly qualified staff, such as social workers and psychiatric nurses,
- greater emphasis on outpatient activities,
- separation of the mentally retarded from those with psychiatric illnesses,
- initiating research into the causes of psychiatric illnesses.

The provincial government responded by developing training programmes for the hospital staff, setting up a psychiatric ward at the Regina General Hospital and placing mental health services under the unified leadership of Dr. J. W. MacNeill. Unfortunately, the depression, drought and war pushed the remaining suggestions off the government's list of priorities.

In the fifteen years following the Hincks Report only 300 more psychiatric beds were constructed, but the combined population of the two hospitals grew from 2,000 to 4,200.[3] The result was very poor mental health care for Saskatchewan people. The province led the country in both proportion of the population held in mental hospitals and the number of deaths in mental hospitals per capita.[4]

In 1944, the newly elected Premier of Saskatchewan, T. C. Douglas, in a speech to the Provincial Legislature, outlined his government's plans:

> *We are embarking upon a fairly ambitious mental hygiene programme, Mr. Speaker. We have been extremely fortunate in persuading to come to this province one of the outstanding psychiatrists in Canada. Dr. McKerracher is proceeding to organize what will be an up-to-date mental hygiene programme .....more important than the institutions where treatment is given will be the Mental Hygiene Clinics which we hope will .....help us pick up cases in their early stages and provide early treatment.*[5]

Under Dr. McKerracher's leadership, conditions gradually began to improve. In his 1930 report, Dr. Hincks had stressed the importance of qualified professional staff. But it was hard to attract psychiatrists to Saskatchewan and even registered nurses were in short supply in the mental hospitals. After careful consideration, Dr. McKerracher decided that if he could not attract the traditional nurse to mental health programmes, he would have to train his own. Thus, the first classes in the new 500-hour training programme began in the fall of 1947 and the ultimate result was the birth of a new profession - the Registered Psychiatric Nurse.

Dr. Hincks had also cited the problems caused by intermingling the mentally retarded and people with psychiatric illnesses. In 1950, construction began on the Moose Jaw Training School, which later became Valley View Centre. The Prince Albert Training School (later, the North Park Centre) followed. In this way, most of the mentally retarded were separated from the psychiatrically ill and the programmes available for both groups improved.

One of the reasons that conditions had deteriorated so seriously in mental health care was that the problems were often "out of sight and out of mind" of the general public. As Dr. McKerracher wrote:

> *In 1947 the Department of Public Health, recognizing the need for a closer liaison with the public, created a lay visiting committee. This committee of five members, representative of clergy, education, labour, rural municipalities and the women of the province, was activated in 1949. Its commission is to regularly visit the psychiatric facilities and report to the minister. It is serving a useful function in providing the hospitals with the viewpoint of the public while in turn it helps to translate the hospitals' problems to lay groups.*[6]

The 1950's also witnessed several other important developments. First was the development of new antipsychotic drugs. The new drugs did not

prevent or cure mental illnesses but they did make it possible to control some of the symptoms of certain illnesses, enabling many patients to return to or remain in their home community.

Second, Dr. Hincks' National Committee on Mental Hygiene (now re-named the Canadian Mental Health Association) began to organize local branches and provincial divisions. Previously, only the national committee had existed. The first local branch in Canada was established in Saskatchewan by Dr. Sam Laycock in 1949. In 1950, Saskatchewan became the first provincial division of the Mental Health Association. One of the first activities of the new Provincial Association was to organize regular visits to the two hospitals to provide some measure of outside human contact for patients. In addition, the Association organized public meetings to make people aware of the conditions of patients and to help break down the stigma associated with mental illness. By the late 1950's, the Association had more than 15,000 members.

One of the first issues faced by Dr. McKerracher in 1946 had been the possibility of building a new 1,600 bed mental hospital near Saskatoon. Both Dr. McKerracher and his colleague, Dr. Sam Lawson (who succeeded McKerracher in 1955 as Director of the Psychiatric Services Branch) were dubious about the value of large mental hospitals. As early as 1930, Dr. Hincks had expressed concern that patients tended to become "institutionalized" in large hospitals. In other words, they tended to lose some of their basic living skills in an overcrowded impersonal environment in which everything was done for them. In a famous article published in the late 1950's, Dr. Lawson outlined some of the negative features associated with the large mental hospitals:

> Those patients who are not discharged within 12-14 months tend to remain in hospital indefinitely because the large mental hospital provides a culture of its own to which the patients adapt themselves and reduces the possibility of their re-adaptation to the outside community culture. One

> may say that the chronic hospitalized mentally ill are produced by the hospital or that chronic mental illness is an iatrogenic condition or, to be more specific, a psychiatrogenic illness.
>
> The isolation, together with the mystery surrounding the mental hospital, has maintained the stigma historically attached to mental illness. Relatives are not able to visit the patient readily and touch with him is lost. The family tends to regard the patient as dead both because of the difficulty of visiting and the shame implied by the stigma on mental illness.
>
> The large building containing thousands of patients is productive of impersonality - a quiet unobtrusive patient is easily lost to individual attention and treatment and is only a number on the daily count of his ward.
>
> Large wards containing up to 100 patients prevent any suggestion of privacy and when there is also, as there is in most hospitals, gross over-crowding, no privacy of person or effects is possible. Toilet and washing facilities have to be used on a mass production line basis, again emphasizing the impersonal atmosphere. Eating facilities suffer from the same production line attitudes, food is often unpalatable and cold.
>
> Satisfactory interpersonal and social relations have been found to be impossible where groups number over 12 and the optimum size of such groups has been found to be about 7 or 8. Large units render such grouping impossible. Separation into groups suffering from the same type of mental symptoms may be possible in the gross but segregation into groups of the same age or education or personal habits cannot be attained.[7]

For these reasons, both McKerracher and Lawson rejected the idea of building a new hospital. Instead, they began working on a completely different approach which was based largely on an expert report issued by The World Health Organization in 1953. Dr. McKerracher (who by now had become the first Head of the new Department of Psychiatry at University Hospital) and Dr. Lawson each emphasized different elements in the new approach. McKerracher felt that the new antipsychotic drugs made it possible for most patients to be treated in general hospitals. Lawson was

concerned that psychiatric patients might not receive appropriate care in general hospitals and argued for small specialized inpatient facilities. Both agreed, however, on two key principles:

1. Good medical and counselling services should be available close to where people live and work, in order to allow early intervention in emotional and psychiatric difficulties.

2. Rehabilitation should be provided in order to help patients back to a more normal life in the community and to reduce the likelihood of readmission to hospital.

These two principles were the basis for what eventually became known as "The Saskatchewan Plan", the new approach that was to earn the province an international reputation as a pioneer in improving mental health care.

In the early 1960's, the Saskatchewan Plan began to become a reality. The opening of the Yorkton Psychiatric Centre in 1964 marked an important milestone. The Yorkton Centre emphasized outpatient care, a team approach involving all of the mental health professionals, the decentralization of services into rural areas and the reduction in the length of time people spent in mental hospitals. The success of this new approach surprised even the most optimistic planners. Of the 120 beds that were provided, fewer than half were actually ever needed once the other elements of care were provided.

On the whole, the introduction of the new approach proceeded without major difficulties. Problems did arise, however, in Weyburn where the move to deinstitutionalized care resulted in a drop in the inpatient population from 1,519 in January, 1963, to 421 in June, 1966. This was the sharpest decline in population of any hospital in Britain or North America.[8] Community concerns led to the formation of an ad hoc committee composed of eight people, four each representing the provincial government and the city of Weyburn. Although committee members began with serious concerns about the situation, in the end they recommended:

> *That the Saskatchewan Plan, based on a complete regionalization of psychiatric care in order to make psychiatric attention available locally, be fully and enthusiastically endorsed by the government of Saskatchewan, and that the government proceed immediately to establish the necessary facilities and staff for the implementation of the programs on a province-wide basis.*[9]

While the ad hoc committee's report was an important signal of public support for the principles and concepts of the Saskatchewan Plan, the committee's report stimulated consideration of some of the weaknesses in its actual implementation. In a report prepared for the ad hoc committee, Dr. Colin Smith, Director of Psychiatric Services Branch, outlined eight issues:

1. *There were many more patients with psychotic symptoms in the community than formerly, who posed problems to themselves or relatives and to the community.*

2. *Good follow-up is essential to ensure that they are adequately cared for and that drugs are taken as recommended.*

3. *More nurses and other community personnel must be trained and used in this field, and their training adapted to enable them to deal with emerging problems.*

4. *The community workers must be sensitive to the social stresses which result from the patient's placement in the community. Neither the patients nor those associated with them should be allowed to suffer unnecessarily.*

5. *A truly therapeutic environment must be created for these patients with all that this implies in terms of sheltered employment, recreational therapy and so on. Homes in which the patients are placed must not become small and inferior institutions.*

6. *Psychiatric facilities must be prepared to readmit these patients if and when circumstances are warranted. They must take account of social, psychological and biological factors in determining whether or not admission is necessary.*

7. *The decline in hospital population and increase in community patients presents difficulties to professionals and the community alike. The problems must be tackled imaginatively and backed by a good public education program.*

8. *Research studies are urgently needed of the problems connected with maintaining patients in the community and of the effectiveness of various measures to diminish these problems.*

Several years later, Dr. Smith summed up the situation in the following words:

> *.....despite all the stresses and strains and a good deal of criticism, no one really doubted the direction in which the program was going. However, the need for more careful monitoring was evident and also for putting more dollars and cents into the community program in order to make the transition a smooth one .....*
>
> *Steps began to be taken in these directions in 1967 but they occurred too slowly to avert a temporary crisis in the system.*[11]

The crisis was precipitated by the murder of nine persons at Shell Lake on August 15, 1967. The man charged with the murders had recently been discharged from a provincial mental hospital. Public anxiety became acute. In order to address this public anxiety, the Minister of Health invited Dr. Shervert Frazier of Texas, to study Saskatchewan's psychiatric services and make recommendations. Dr. Frazier's report strongly endorsed the principles upon which the Saskatchewan Plan was based -- regionalization, care close to home, hospitalization only when necessary, home placement, etc. Frazier found that the people of Saskatchewan were not only supportive of the Saskatchewan Plan, but actually proud of the province's record of leadership in the field of mental health. He described the Yorkton Psychiatric Centre as a model of how a community psychiatry programme should function.

Dr. Frazier pointed out, however, that "neither the original 'Saskatchewan Plan' nor any modification has ever been fully implemented".[12] Instead,

he noted that there had been a "gradual financial squeeze" on the Psychiatric Services Branch. This financial squeeze had resulted in unsatisfactory salaries and working conditions and an exodus of key professionals. He described the situation as follows:

> *The province has gradually drifted into a situation in which it is trying to run a first-rate program on a second-rate budget, and this simply will not work. As a result, quality of care is slipping, duties are being reassigned to less qualified personnel, caseloads are increasing, and work days are becoming longer, all contributing to demoralization.*[13]

Like Dr. Smith, Dr. Frazier expressed concern about the quality of community care for people who had been released from hospital. Many of the briefs that he received from the public suggested that "home placements were relatively barren, that patients were being placed in 'little institutions', (and) that there were limited social and recreational opportunities".[14]

Dr. Frazier's report contained 47 recommendations, some of which were:

1. An increase in the Psychiatric Services Branch Budget.
2. An improvement in salaries and working conditions for professional staff.
3. An increase in community staff.
4. An enrichment of outpatient care, including:
   - sheltered workshops
   - half-way houses
   - day treatment centres
   - vocational rehabilitation programmes
   - additonal recreation
   - social clubs
   - nutritional guidance
   - classes in personal hygiene
5. Orientation and training programmes for approved home operators.
6. An easing off in the pressure for discharges.
7. The development, publication and regular up-dating of long-range plans for mental health care.

8. The construction of a Research and Training Institute.
9. The establishment of a province-wide system of programme evaluation.
10. Improved communication between general practitioners and the Psychiatric Services Branch.[15]

The provincial government took several steps in response to Dr. Frazier's report. The mental health services budget was increased by the largest amount in its history. Professional salaries were improved substantially. There were dramatic increases in the number of professional staff and twenty-five new community positions were established. More funding was provided to the Mental Health Association for community programmes.

Work was begun on a new comprehensive long-range plan and specific plans were developed for the proposed research and training institute, and a facility for mentally ill offenders.

Meanwhile, the trend to community mental health care across North America brought two important changes. First, the mandate of mental health services was increased dramatically. Help was provided not only to people with serious psychiatric illnesses but to the much larger number who suffered from milder emotional difficulties or "problems of living". Second, deinstitutionalization moved hundreds of thousands of psychiatrically disabled people out of the mental hospitals into the community.

As the number of non-medical mental health professionals exploded, new ideas developed about professional roles. Psychologists, social workers, nurses, and even occupational therapists, were attracted by the prospect of doing psychotherapy and group counselling. New psychological theories were developed and widely debated. The publication of "self-help" books for people with emotional problems became a growth industry. Countless numbers of group therapy techniques enjoyed a fleeting but well-advertised existence. As horizons expanded, there was an increasing blurring of professional roles.

The traditional leading role of psychiatrists was challenged. Psychiatrists were often associated with "the bad old days" of mental hospitals. The side effects of the new psychiatric medications and an occasional tendency towards the inappropriate treatment of personal and social problems with drugs provided the grounds for a sharp attack on the "medical model". In its more extreme and widely publicized versions, this attack led some people to deny the very existence of mental illness.

In this context of conflict both within and between the different professions, mental health services presented an increasingly vulnerable target for governments that were looking for areas in which spending could be cut, either out of a general policy of fiscal restraint or simply out of a desire to find money for other programmes. In the era of deinstitutionalization, mental health services were one of the few human service areas where politicians could cut back expenditures without causing a public outcry.

Thus, while the community mental health approach brought major improvements, it also led to certain problems. These problems have been especially concentrated on people with psychiatric disabilities. On the positive side, deinstitutionalization has given most of them a greater degree of personal freedom and dignity. On the negative side, as the mandate of mental health services had broadened, professional interest has increasingly focused on the "worried well" rather than the mentally ill. The fact that some professionals have denied or down-played the reality of mental illness has driven a deep wedge between these mental health professionals and the public, particularly that portion of the public who are the friends, neighbours and relatives of people with psychiatric illnesses. Perhaps most important, these developments helped to disperse the fragile impetus that had been generated by deinstitutionalization to establish the needed supports for psychiatrically disabled people who are trying to live a more normal life in the community.

In Saskatchewan, the 1970's were a period of relative stagnation in mental health services. The momentum generated by the reports of the ad hoc committee and Dr. Frazier gradually dissipated. Government and public interest shifted to new areas. In 1972, a new agency was set up to provide services to disabled people and the Psychiatric Services Branch lost responsibility for the mentally retarded. In 1973, the Psychiatric Nursing Training Programme was transferred from the mental hospitals to the Wascana Institute. The number of staff in the Branch declined steadily. In constant dollars, budgets dropped from nine and a half million dollars in early 1970's to less than eight million dollars by 1976-77.

Dr. Hugh Lafave, who succeeded Dr. Smith as Director of Psychiatric Services Branch in 1976, did not take long to pinpoint a major problem. In a paper delivered in September, 1977, he stated:

> *Since 1963 .....the readmission rate has risen and exceeded that of first admission ..... The resources and emphasis on outpatient programs peaked out....and did not keep pace with needs resulting in some back sliding of care.....We see the present increase in admissions as reflecting a need to expand and revitalize community programs to reverse this trend.*[17]

Despite the fact that Dr. Lafave identified the problem and recommended a revitalization of community programmes, little action was forthcoming. As the problems resulting from inadequate community programmes continued, nursing home operators, the police, the medical profession and the public all became increasingly concerned. It was in response to this widespread and growing concern about the quality of mental health care that the Mental Health Association decided in May, 1980, to establish the Task Force on Mental Health Services in Saskatchewan.

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otnotes

1. Colin M. Smith, "Necessity and Creativity: Innovations in Service Delivery in Saskatchewan Pre and Post War," Talk given at the Saskatchewan Psychiatric Services Annual Clinical Conference, Regina, October 16, 1980, p.2. Maurice Demay, "The Beginnings of Psychiatry in Sask.," Canada's Mental Health, Volume 21, Number 1, p.24.

2. Ibid., p.5

3. Ibid., p.5

4. Colin M. Smith, "Crisis and Aftermath: Community Psychiatry in Saskatchewan, 1963-69," Canadian Psychiatric Association Journal, Volume 16, Number 1, February 1971, p.65

5. Quoted in Colin M. Smith, "Necessity and Creativity", op. cit., p.8

6. D. G. McKerracher, "Some Historical Aspects of Psychiatric Developments in Saskatchewan," Saskatchewan Psychiatric Services Journal, Volume 1, 1952, p.5

7. F. S. Lawson, "Mental Hospitals: Their Size and Function," Canadian Journal of Public Health, Volume 49, May 1958, p.187

8. Shervert H. Frazier and Alex D. Pokorny, "Report of a Consultation to the Minister of Public Health on Psychiatric Services of Saskatchewan," p.5

9. The Report of the Ad Hoc Committee on the Resettlement of Mental Hospital Patients to the Minister of Public Health (Regina, 1966), p.31

10. Quoted in Colin M. Smith, "From Hospital to Community: A System Changes", Canadian Journal of Psychiatry, Volume 24, Number 2, March 1979, p.116

11. Ibid., p.116-17

12. Shervert H. Frazier and Alex D. Pokorny, op. cit., p.37

13. Ibid., p.38

14. Ibid., p.24-25

15. Ibid., p.39-45

16. Province of Saskatchewan, Estimates for 1972-73 and 1976-77. Adjustment for inflation are based on the Canadian Implicit Price Index.

17. H. G. Lafave, "Mental Health in Saskatchewan: A Look at the Past, Present and Future". Paper presented at the Annual Meeting of the Canadian Psychiatric Association, Saskatoon, September 28-30, 1977, p.10

IV EXISTING TREATMENT SERVICES

INTRODUCTION:

Historically the provision of mental health service in this province has been the responsibility of the provincial government. Until the 1950's the government mental health programmes provided almost all mental health services. However, with the advent of psychoactive drugs and the growth of the private sector and general practice psychiatry, the government's role has been gradually reduced over the years. In spite of this the Psychiatric Services Branch, in terms of numbers of staff and volume of services, remains the major service agent in the total mental health system.

In order to understand the mandate of government programmes, one looks to their enabling legislation. An example of this is "An Act to establish the Alcoholism Commission of Saskatchewan". This Act spells out "aims, objects and powers of the commission"; e.g. to sponsor, conduct and promote programmes of research, treatment, education, etc.

"An Act respecting Mentally Disordered Persons" known as the "Mental Health Act" is much less precise. The only reference to programmes is in Sec. 5:

> *"5.- (1) The department may organize and operate programmes for the provision of diagnostic and treatment services to outpatients and mentally disordered persons in various communities throughout the province to the end that psychiatric services will be reasonably available to all residents of the province.*
>
> *(2) In the operation of such programmes the minister may provide through employed personnel the services of psychiatrists, physicians, psychiatric nurses and psychiatric social workers and may also provide drug therapy and other services to such extent and upon such conditions as he may consider advisable. 1970, c.43, s.4."*

It would appear that the basis for the existing provincial mental health service is not to be found in legislation or official government policy but in a paper authored by Drs. Lawson and McKerracher which was presented to the American Psychiatric Association Mental Hospital Institute, at their Annual Meeting in Denver in October, 1956. This paper provided the blueprint for subsequent programme development in Saskatchewan. It was used as a bench mark by Dr. Frazier when he reviewed the provincial programmes in 1968.

The paper embraced two basic concepts: The regionalization of mental health services and the phasing out of the large mental hospital. The regional service would operate out of the small community mental hospital. In Lawson's words:

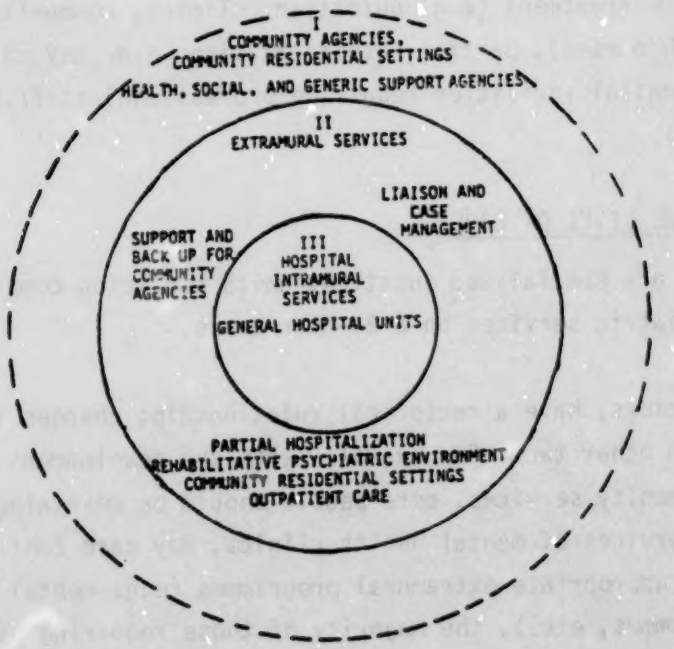
> *"The community hospital will make it possible to provide such variations of service as day hospital care, night hospital care, weekend care, and hostel accommodation for patients who are being rehabilitated in their jobs. These are services which make it possible to adapt the treatment of the circumstances or occupation of the patient and, therefore, make it possible to give the necessary treatment with a minimum of disruption of the patient's life and work. The more this can be done, the less difficult becomes the rehabilitation of the patient. Where these services have been tried, they have been found extremely valuable in reducing hospital admissions and hastening recovery. They cannot be carried out in mental hospitals which are remote from the communities which they serve."*

The movement from institutional to community care was assumed that the services provided by traditional mental hospitals could be provided in the community at less cost to the individual as well as to the public. That is to say, diagnosis, treatment, rehabilitation, social programmes and shelter could be relocated in the community without the risk of producing, in Lawson's words, a "psychiatrogenic illness".

In examining the existing treatment service in Saskatchewan, the Task Force decided to look at medical and non-medical components separately. In this Chapter we examine those services which involve diagnosis and/or treatment, i.e. "medical" component. In Chapter V we will examine the non-medical services; i.e. shelter, vocational/rehabilitation programmes, socialization programmes and income support.

A criticism of an Interim Report was that in approaching existing services from the standpoint of target populations, we took a fragmented look at what is, in effect, an integrated system. In this Final Report, we have followed the model used by Dr. Alex Richman in the Southern New Brunswick Mental Health Planning Study, March 1, 1982. (fig. 1).

(FIGURE 1)
INTEGRATED SERVICE SYSTEM



* Report of the Southern New Brunswick Mental Health Planning Committee, March 1, 1982; p.7

PSYCHIATRIC SERVICE SYSTEM

A. COMMUNITY LEVEL OF CARE:

This includes all those services that are available for the physically and mentally ill within a community. Two essential features of community services are that they are non-specialized and accessible to the community at large; e.g. residential settings, sheltered workshops, community recreational centres, general practitioners, social services, educational upgrading programmes, meals on wheels, etc.

B. EXTRAMURAL LEVEL OF CARE:

Those services provided by the mental health professionals, specifically for patients identified as having "psychiatric" problems. While not requiring inpatient care, these patients still require some "psychiatric" supervision. These services include treatment (e.g. outpatient clinics, community mental health nurses), partial hospitalization (e.g. day care) and residential facilities requiring professional staff;(e.g. group homes).

C. INTRAMURAL LEVEL OF CARE:

These are specialized inpatient units providing comprehensive psychiatric services on a 24-hour basis.

These three sectors, have a reciprocal relationship; changes in one invariably affect the other two. For example, with the development of appropriate numbers of community services, more people should be maintained without the need for the services of mental health clinics, day care centres, etc. In addition, with appropriate extramural programmes (e.g. mental health clinics, day care programmes, etc.), the majority of those requiring psychiatric

intervention could be maintained in the community without the need for hospital care. Finally, with appropriately designed and staffed inpatient facilities, those patients needing 24-hour care would be treated effectively and efficiently for shorter periods of time, thus reducing the risk of institutionalization. At discharge they would be better prepared to return to their families and their home communities than had been the case with the old mental hospital.

The deinstitutionalization movement believed that mental health services should provide hospital care when necessary but not necessarily hospital care. This would be achieved by providing alternatives to institutional care through the development of Extramural and Community Programmes. Thus, the four functions of the "asylum" (diagnosis and treatment; maintenance and support; vocational/rehabilitation; socialization and leisure) could be provided to those in need with the least amount of disruption to the patients, their families and the community. The success with which Saskatchewan has met these needs in the four areas mentioned above will be discussed in this and the next chapter.

A. COMMUNITY LEVEL OF CARE:

> *.....the person seeking help is highly subject to the influence of non professional primary group members in the community. These informal agents of influence affect the individual's health care in two ways: first, they serve functions which parallel those of human service bureaucracies by providing various forms of alternative direct assistance to the individual; second, they mediate the individual's relationships to these bureaucracies by influencing his utilization behaviour.*
>
> *- Gottlieb, B.H., Canadian Psychological Review; Vol. 17, No. 2; Apr/76; pp. 126-7.*

In recent years social scientists and mental health professionals have become increasingly aware of the important role played by various community members and groups in providing support and "treatment" to individuals in distress. Gottlieb identifies four such community groups:

(a) Social Networks - e.g. family, friends and colleagues
(b) The Neighbourhood
(c) Self-Help Groups - groups of persons who share common problems
(d) Community Gatekeepers. (By this is meant a variety of representatives of health, educational, religious and legal systems in the community who, although not primarily in the mental health field, are frequently the initial "professional" contacts made by the patients and their families.)

(a) Social Networks:

An individual in an acute stress situation (e.g. bereavement, illness, job loss, marriage breakdown) frequently turns to someone in their immediate social circle with whom they have established a close, stable and trusting relationship. This could be a family member, friend or co-worker.

The kind of assistance that this individual can provide will depend on their knowledge, experience and particularly the amount of stress they too are under at the time. During the periods of family stress (e.g. unemployment, illness, migration, etc.), the family may not be able to meet the needs of the individual and, thus, will direct them elsewhere. In most instances, however, the help provided by members of this network is sufficient to enable the affected person to weather the crisis.

The Task Force recognizes the family as the key component of the community support system. Whether the affected family member is a Down's Syndrome child, a dementing grandparent, a schizophrenic young adult or an alcoholic husband, the family traditionally provides the first line of support. However, the amount of support the family can provide will depend on its "health". With respect to this, many briefs expressed concern about the growing pressures on Saskatchewan families today and the effect they have on the stability of the families. The brief of the Saskatoon Family Service Bureau entitled, "Enemies of the Saskatchewan Family", identified fourteen "enemies" in this brief including poverty, drugs, the workplace and migration. This submission called for more sensitivity on the part of government to the impact of social change on families.

A perceived lack of sensitivity on the part of government and its agencies to family needs was also expressed by parents and relatives of patients involved with the mental health system. A frequent complaint was that because of the lack of appropriate services an undue burden was placed on families who, rather than abandon their relatives to the streets or to the back rooms of residential hotels, continued to give support at considerable personal and financial expense. This concern was echoed by a number of professional groups, especially community mental health workers.

Many government programmes, policies and legislation have a significant impact on the stability and welfare of the family. These range from

curriculum changes in education to amendments to liquor legislation. Because the family plays such an important role in maintaining the health of its members, it is essential that its own "health" be protected. In order to achieve this, THE TASK FORCE RECOMMENDS:

1. THAT THE GOVERNMENT ESTABLISH A SPECIAL INTERDEPARTMENTAL COMMITTEE TO REVIEW ALL NEW GOVERNMENT ACTIVITIES, POLICIES AND PROGRAMMES WHICH IMPACT ON THE FAMILY.

2. THAT GOVERNMENT PROGRAMMES PROVIDE SUPPORT TO THOSE FAMILIES CARING FOR DISABLED MEMBERS, THROUGH THE PROVISION OF A RANGE OF RESPITE SERVICES INCLUDING DAY CARE, EVENING CARE, AND RESPITE BEDS.

3. THAT SECTIONS 6 AND 7 OF THE FAMILY SERVICES ACT BE IMMEDIATELY IMPLEMENTED.

4. THAT LEGISLATION BE ENACTED TO PROVIDE FINANCIAL SUPPORT TO FAMILIES WHO WISH TO KEEP DISABLED FAMILY MEMBERS AT HOME WHERE THIS IMPOSES A SIGNIFICANT FINANCIAL, PHYSICAL OR EMOTIONAL BURDEN ON THE FAMILY.

(b) The Neighbourhood:

In Saskatchewan "Neighbourhood" may mean a city block, an apartment building, a residential hotel. In rural areas it may be a village or adjoining farms. Neighbourhoods vary in the degree of cohesiveness and organization. Thus, the amount of support provided will vary from neighbourhood to neighbourhood. In rural areas the decrease in the number of farms plus improved means of transportation may make rural residents less dependent on the traditional support of neighbours and more inclined to use professional services in neighbouring towns and cities. However, in areas where there remains strong neighbourhood ties due to common ethnic and/or religious bonds, the neighbourhood continues to play an important supportive role.

The Alcoholism Commission of Saskatchewan is one government organization that has recognized the need to stimulate interest in small communities and neighbourhoods (through Home and School Associations) about a common concern - the frightening growth in the use and abuse of alcohol and drugs. The very successful Mini Course developed by the Commission is a "model" of how communities' awareness can be raised through the involvement of community leaders through means of a four-and-a-half day Immersion Programme at the Calder Centre in Saskatoon. This innovative programme, which has attracted people from all walks of life, has been universally praised by those who have taken part in it. These people in turn provide leadership in their community in identifying local needs and resources. Their initiative considerably enhances the impact of the Commission's programme. The parallel between alcoholism and mental illness is obvious. They both represent health issues that heretofore had not enjoyed a high priority in the minds of government planners nor, indeed, the community as a whole.

It is obvious that if a community mental health system is to be effective, it needs the acceptance and support of the community itself. The Task Force was informed of situations where efforts to establish group homes and treatment centres in community settings were met with great resistance. This would suggest that public attitudes need to change. However, there was little evidence to indicate any concerted effort on the part of government or non-governmental agencies to change public attitudes towards mental illness and mental health programmes. Inasmuch as the community level of care plays an essential role in providing support as well as assisting in the rehabilitation and reintegration of disabled members into the mainstream of community life; THE TASK FORCE RECOMMENDS:

5. THAT A HIGH PRIORITY BE GIVEN TO THE DEVELOPMENT OF INNOVATIVE PROGRAMMES DESIGNED TO IMPROVE PUBLIC AWARENESS, UNDERSTANDING AND ACCEPTANCE OF THE MENTALLY ILL AND MENTAL HEALTH PROGRAMMES.

(c) Self-Help Groups:

These are informal organizations of people with shared concerns such as illness (of self or family members) or common "causes". In the course of our proceedings, the Task Force received a number of briefs and submissions from such groups. Some were groups of individuals who shared common problems (e.g. agoraphobics, widows, former patients) others performed a lobbying or advocacy function (The Saskatchewan Association of Mental Retardation; the Schizophrenia Foundation of Canada; The Mental Health Association of Saskatchewan).

As a general observation, the Task Force is convinced that the self-help movement is flourishing in Saskatchewan. This observation is in marked contrast to comments made by several professionals to the effect that "voluntarism" in this province was on the wane. Nonetheless it is fair to say that Saskatchewan appears to lag behind other parts of the country in the extent to which the self-help movement has developed. As an example, "patient" self-help groups have only recently been formed in Regina and Saskatoon, whereas in Vancouver and Toronto they have been well established and have grown into powerful lobby groups having a major effect on government legislation and programmes. In spite of the late development of the self-help movement, there were examples of some remarkable success stories. One of these was the Saskatoon Community Contacts for the Widowed. This group, although organized only two years ago, has rapidly increased its membership and already is filling an important service in the community. In view of the established relationship between bereavement and physical/emotional morbidity, such a group can play an important preventative and rehabilitative role in the community.

The best known and oldest major self-help group is Alcoholics Anonymous. The success of this movement is reflected in its growth since 1935, from a single group to what is now an international movement. Along with

its related organizations of Alanon and Alateen, it provides services to a large group of individuals who frequently have failed to respond to traditional, medical and social programmes. This is an example of a self-help group that insists on providing treatment and rehabilitation resources within the community without the benefit of government support or involvement.

These groups underscore the point that mental health services need not, and indeed should not, be restricted to government or professional organizations.

Self-help groups, in many ways, may be more effective than government agencies in bringing help and assistance to afflicted individuals in the community. Because they are of the community and not just in the community, self-help groups are more likely to be aware of people in need. Also, because they are informal rather than bureaucratic organizations, they are less imposing and less inhibiting; thus, making it easier for the "client" to approach them or to be approached.

Their informality frees them from professional traditions or bureaucratic regulations. Frequently, this enables them to be more responsive. Finally, by their very nature they promote the idea of responsibility for one's health; thus, encouraging the individual to be more self-reliant and less dependent on government or other formal organizations. In this way, self-help groups represent a partial answer to the growing concern about government intervention in our daily lives.

It is obvious that we should be encouraging the development of more self-help groups across the province. But in spite of the overwhelming evidence of the contribution made by these groups to mental health needs of our community, there appeared to be little in the way of formal recognition by government either in terms of professional liaison activities or financial support. In view of this,

THE TASK FORCE RECOMMENDS:

6. THAT THE GOVERNMENT AND PROFESSIONALS RECOGNIZE THE IMPORTANT ROLE OF SELF-HELP GROUPS IN THE OVERALL MENTAL HEALTH SYSTEM AND THAT GREATER EFFORT SHOULD BE MADE TO PROMOTE AND SUPPORT THESE ORGANIZATIONS THROUGH FINANCIAL AND CONSULTATIVE ASSISTANCE.

The Task Force received submissions from a variety of organizations that could be called 'special interest groups'. The Canadian Schizophrenia Foundation for example made several presentations and were well represented at the Public Hearings. This group is an excellent example of how organizations can and do mount strong and persuasive lobbies. We were aware that this organization has successfully transmitted its message to the public and to governments not only in Saskatchewan but in other provinces of Canada.

The Task Force also noted increasing involvement of the Canadian Association on Mental Retardation in the field of client advocacy. This organization, through the co-operation of its national headquarters and provincial affiliates, is developing a very effective advocacy system across this country.

A third major special interest group is, of course, the sponsoring organization for this Task Force; namely, the Mental Health Association of Saskatchewan. This organization was founded in 1950 and was the first provincial division of the national organization. The moving force behind its development was Dr. S. Laycock, a noted educationist and psychologist.

In its early years, the Association concentrated on improving the conditions in the two provincial mental hospitals and providing public education programmes. By the mid 1950's it had a membership of approximately 15,000. It was a highly visible, credible organization and was successful in attracting members from all walks of life. At the time it had few rivals and, thus, enjoyed more than its share of publicity. Undoubtedly,

part of its success was related to the general air of optimism about the future of mental health.

In the ensuing three decades, much has changed. The mental hospitals which were the focus of so much of the Association's activities no longer exist. The optimism about prospective "breakthroughs" in psychiatric treatment gradually waned over time. The emergence of scores of other special interest groups (e.g. Human Rights, Cystic Fibrosis, etc.), have affected its public visibility. It is obvious that this organization no longer enjoys the high profile that it once did.

The Task Force recognizes that the Saskatchewan Mental Health Association continues to supply much needed rehabilitation and socialization services. In fact, without the Association's activities in this field these services would be almost non-exsistent. In general, we believe the provincial organization has accepted too broad a responsibility and attempts to be all things to all people.

The Task Force was concerned about how dependent the Mental Health Association is on the provincial government for both financial and human resources. A significant portion of its budget is provided through a grant from the Psychiatric Services Branch of the Department of Health, and a major portion of its Board membership is made up of civil servants from the Departments of Health and Social Services. The Task Force Committee feels that such an arrangement, necessary as it may have been for the sustenance of the Association in the past, does raise the issue of conflict of interest. Can this Association, given its special relationship to the provincial government, effectively carry out an advocacy role? Certainly the information we have received from public and professional groups would suggest that our mental health services are in dire straits. The evidence would suggest that this condition is, in large part, due to government inaction or, in some instances, deliberate government policy.

The Association must, therefore, be in a position to criticize the government publicly. We question whether this can be done adequately under the present arrangement.

A second issue relating to advocacy is that of increasing competition for scarce health dollars. Governments are faced with spiraling health costs and increasing expectations for health services. It is understandable that the public wishes the best medical care available. But many new techniques and treatments involve tremendous outlays of money. CAT scans, neonatal intensive care, organ transplants, cardiac surgery--are all heavy consumers of health dollars. Mental health services lack the glamour of other medical programmes; yet mental disorder, in all its forms, is the major health problem in the country today. If we are to reduce the cost in human suffering and misery, we need to improve our present system. In order to redress the current imbalance in the funding of health programmes, it is essential that the public be made aware of the problems facing mental health programmes. It is only when the public becomes informed and concerned that our political leaders will ensure a more equitable division of the health budget.

As a first step in public education programmes we feel that the Association should significantly increase its membership. It should also recruit those people in the community who have demonstrated leadership qualities. These two steps will enhance the overall effectiveness of the Association in its lobbying efforts. The Task Force suggests that in addition to focusing on its advocacy role, the Association increase its activity in the field of public education.

THE TASK FORCE, THEREFORE, RECOMMENDS THAT:

7. THE MENTAL HEALTH ASSOCIATION MAKE ADVOCACY ITS TOP PRIORITY.

8. THE MENTAL HEALTH ASSOCIATION SIGNIFICANTLY INCREASE ITS EFFORTS IN THE FIELD OF PUBLIC EDUCATION.

(d) Community Gatekeepers:

As Gottlieb points out, a number of large scale surveys .....

> *"..... have amply documented the theme that persons seeking help for mental health linked problems typically do not engage mental health professionals but turn instead to a variety of representatives of health, education, religious and legal institutions in the community."*

Many professionals in the community, while not directly involved in the mental health system do provide mental health services as a part of their work. Doctors, clergymen, social workers, guidance counsellors may by consulted for assistance with personal, marital or family problems. In both rural and urban areas police are often called upon at times of personal or family crisis. These professionals perform a front line function for the entire mental health system.

Within many communities private agencies that supply social, counselling and other services may also be consulted for help with the emotional difficulties of individuals, parents or couples. Family Service agencies, crisis intervention groups, rape crisis/sexual assault and information centres, and crisis lines are examples of community agencies providing multiple services to people in turmoil. How often these agencies are used and how effective they are will depend not only on their availability and accessibility but on their reputation in the community and among other agencies and professionals.

Certainly in the field of community service, the urban centres appear well served. However, the Task Force was informed that there was need for better integration and co-ordination even among these services. It was reported that there was a tendency for overlapping or duplication of many services simply due to the lack of knowledge of existing programmes. Frequently clients left to their own devices try a number of resource agencies, often without revealing previous contacts with others. The resultant

inadequate service is not caused by a lack of resources but because of poor communication and integration. Fragmentation of human services at the community level frequently leads to poor communication, unnecessary duplication of services, discontinuity of care and an inefficient use of precious tax dollars.

A common complaint, especially of parents whose children had been the recipients of services, was the lack of information about services available in the community. There was a special plea for regional inventory of all human service programmes. In view of the high turnover of personnel and changes in programmes, it was obvious that this type of inventory would require a frequent update.

Based on its own experience in attempting to identify agencies in the mental health field, the Task Force was especially sympathetic to these concerns about fragmentation and lack of co-ordination. The Committee agreed that a directory of services should be prepared for each region. Inasmuch as the Department of Social Services is the major participant in this field, the responsibility for compiling these directories should rest with it. THE TASK FORCE RECOMMENDS:

9. THAT AN INVENTORY OF ALL HUMAN RESOURCES, GROUPS, AGENCIES, ETC., BE COMPILED FOR EACH REGION. THE RESPONSIBILITY FOR THIS AND ITS CONTINUING UPDATING SHOULD REST WITH THE DEPARTMENT OF SOCIAL SERVICES.

Dr. McKerracher, Co-ordinator of "The Saskatchewan Plan" and first Professor of Psychiatry at the University of Saskatchewan questioned whether Saskatchewan could ever recruit sufficient numbers of psychiatrists to meet its needs. Because of this he felt that the family physician would carry the major responsibility to provide these services. Accordingly, his medical education should equip him for this role.

Twenty-five years later, a study by the Applied Research Unit of the Psychiatric Research Division of the Psychiatric Services Branch indicated

that 80% of all patients receiving only outpatient care for a psychiatric problem received it entirely from family practitioners. Of these individuals, the vast majority were suffering from moderately severe psychoneurotic disorders or personality problems. Only 5% were suffering from major or psychotic disorders. This study also revealed that 58% of all psychiatric inpatients were treated in general hospitals by private physicians. The majority of those patients treated in general hospitals suffered from psychoneurosis or alcohol-related disorders.

The Medical Care Insurance Commission Annual Reports would indicate that the major providers of psychotherapeutic services in Saskatchewan are general practitioners. The billing for this service has increased by approximately 200% between the years 1975 and 1980.

These studies would tend to support McKerracher's hypothesis that the general practitioner would be the major source of psychiatric treatment. It is important then to examine the quality of this service.

The quality of any general practitioner's service will depend on a variety of factors including their training, their knowledge, their experience, their interest, and the time available to them for such items of service as "counselling" and "psychotherapy". Some submissions to the Task Force, and in particular those from representatives of mental health professionals, questioned the competence of any general practitioner to do psychotherapy. Other submissions questioned the prescribing practises of many general practitioners and particularly the trend towards prescribing more mood modifying drugs to young women than is the case for their male counterparts.

Although a formal study has not been undertaken of the effectiveness of General Practise Psychiatry in Saskatchewan, psychiatric consultants informed us that increasing numbers of family practitioners were interested in treating their own psychiatric patients. The increasing number of Saskatchewan graduates practising in the province may be a partial explanation for this.

The continuing problems in recruiting and retaining adequate numbers of mental health professionals mitigates against the probability of supplanting the general practitioner as the major provider of psychiatric treatment. It is essential, therefore, that they not only receive adequate undergraduate training but that they also be provided with the opportunity for continuing their education in psychiatry so as to ensure that their knowledge and skills are maintained at an adequate level.

Medical Undergraduates at the University of Saskatchewan receive 315 hours of teaching in the Department of Psychiatry prior to their graduation. Although this represents a considerable improvement over previous years, nonetheless their practical experience is limited because of inadequate numbers of teaching staff in the department. This problem is not new. It has been identified many times over the years by visiting Accreditation Committees. As a first step towards assuring an adequate training in Psychiatry for Medical Students, THE TASK FORCE RECOMMENDS:

10. THAT STEPS BE TAKEN TO IMPROVE THE UNDERGRADUATE TRAINING OF MEDICAL STUDENTS THROUGH AN INCREASE IN THE TEACHING STAFF AND THE PROVISION OF MORE CLINICAL EXPERIENCE FOR MEDICAL UNDERGRADUATES.

On graduation from the College of Medicine, the student is required to take a year of internship in order to become eligible for licensure. It is interesting to note that in Saskatchewan a rotation through Psychiatry is not mandatory. This seems inconsistent with the evidence that a substantial portion of general practitioners' patients will suffer from either primary emotional disorder or a disabling emotional response to physical disease. It would seem that the internship, coming when it does after the completion of what might be termed the theoretical portion of the students' education and just prior to their entrance into medical practice, would be the ideal opportunity for them to sharpen diagnostic and treatment skills. It would provide an opportunity to see more of the minor psychiatric disorders that they are likely to find in their practice as opposed to the major disorders

that they see in the psychiatric units of teaching hospitals. THE TASK FORCE THEREFORE RECOMMENDS:

11. THAT THE REQUIREMENTS FOR PRE-REGISTRATION INTERNSHIP TRAINING BE EXPANDED TO INCLUDE A MANDATORY PERIOD OF TRAINING IN A PSYCHIATRIC TEACHING PROGRAMME.

Given the tremendous information explosion in Medicine, the average practitioner is faced with almost insurmountable difficulties in keeping up with new developments. This is especially true in the case of psychiatric treatment. Traditional Continuing Education Programmes, while adequate in providing quick reviews of literature and research, are not adequate for the development of special skills in counselling, brief psychotherapy or the behaviour therapies. Courses should be provided that would enable interested general practitioners to be trained in an apprentice relationship with a supervising psychiatrist or clinical psychologist. This type of training programme has proven very successful in other specialties (Anesthesia).

A problem associated with the acquisition of special skills (e.g. psychotherapy, behaviour modification techniques or other therapies) centres around the payment for services. The Committee received a brief from one general practitioner who had considerable experience and training in psychotherapy but whose expertise is not recognized under the current MCIC Fee Schedule. Provision should be made in the MCIC Fee Schedule to recognize the special skills of the individual general practitioner. A mechanism for certifying competence in special treatments should be established. This would enable the paying agency to pay at a higher level. This has its precedence in the case of family practitioners who have successfully completed a course in EKG interpretation.

In summary, the Task Force feels that the general practitioner will continue to be the major provider of mental health services in the community. It is essential, therefore, that all of their training up to and including the pre-registration internship should be directed towards preparing them for this

role. Furthermore, once in practise, ample opportunity should be provided for them to maintain and develop their psychiatric knowledge and skills. THE TASK FORCE RECOMMENDS:

12. THAT THE DEPARTMENT OF PSYCHIATRY IN CONJUNCTION WITH THE DEPARTMENT OF CONTINUING EDUCATION INVESTIGATE METHODS BY WHICH GENERAL PRACTITIONERS COULD BE PROVIDED WITH SHORT, INTENSIVE TRAINING EXPERIENCES THAT WOULD ENABLE THEM TO IMPROVE THEIR PSYCHIATRIC SKILLS.

13. THAT WHERE A GENERAL PRACTITIONER, UPON COMPLETING A RECOGNIZED TRAINING PROGRAMME, DEMONSTRATES COMPETENCE IN A SPECIAL AREA (AS JUDGED BY THE DIRECTOR OF THE TRAINING PROGRAMME) THAT THIS BE RECOGNIZED BY THE MCIC FEE SCHEDULE.

The community is the major resource for support and "treatment" for those in acute crisis and those with chronic and disabling disorders. In the truly community-oriented mental health system, the community must feel that it has a part in the planning for and the provision of services to its citizens. The Task Force feels that government service agencies should devote more attention to developing strategies for enhancing the role of Social Networks, Self-Help groups, Neighbourhood Support Systems and the indigenous professional groups in the provision of mental health services. To achieve this, THE TASK FORCE RECOMMENDS:

14. THE ESTABLISHMENT IN EACH REGION OF A MENTAL HEALTH ADVISORY COMMITTEE CONTAINING REPRESENTATIVES OF MENTAL HEALTH SPECIALTY SERVICES (PUBLIC AND PRIVATE), COMMUNITY AGENCIES THAT INTERFACE WITH MENTAL HEALTH SYSTEMS, SELF-HELP GROUPS AND THE COMMUNITY AT LARGE.

    THE FUNCTION OF THIS COMMITTEE WOULD BE:

    1) TO PROVIDE ADVICE TO REGIONAL HEALTH, EDUCATION AND SOCIAL SERVICE AGENCIES REGARDING THE ADEQUACY OF EXISTING SERVICES AND THE NEED FOR NEW PROGRAMMES.

2) TO PROMOTE PROGRAMMES DIRECTED AT ENHANCING THE IMPORTANT SUPPORT ROLES PLAYED BY FAMILIES, NEIGHBOURHOODS, SELF-HELP GROUPS AND INDIGENOUS PROFESSIONALS.

B. EXTRAMURAL LEVEL OF CARE:

This consists of those specialized psychiatric services for ambulatory patients who can be maintained in the community through assistance from mental health professionals. This would include services for people suffering from acute and chronic emotional disorders which are provided by psychiatric consultants, mental health clinics, partial care programmes (day and evening care), and community mental health nurses.

Extramural services act as a buffer between Intramural and Community services. They receive referrals from Intramural programmes as well as from general practitioners, social workers, self-help groups, etc., within the community. Extramural services can supply diagnostic and treatment, specialized residential, vocational, rehabiliation and socialization services. They reduce the pressure on the Intramural sector by providing diagnostic and treatment services to the community and through early intervention, avoiding the necessity of hospital care. On the other hand, by providing consultative services to community agencies (including doctors and social workers), they may enable the person in distress to be cared for in his "normal" setting requiring specialized psychiatric care.

In Saskatchewan, Extramural Services are provided by three main groups:

(a) The Public Sector (Psychiatric Services Branch)
(b) The Private Sector (Private Psychiatrists)
(c) University Sector (Dept. of Psychiatry, Univ. of Sask.)

(a) The Public Sector:

The Psychiatric Services Branch operates 14 full-time mental health clinics and 60 part-time clinics. These clinics are staffed by multi-disciplinary

teams (e.g. psychiatrists, psychologists, social workers and psychiatric nurses). They accept patients/clients on referral from physicians, from courts and other social health agencies or as "walk-ins". Some clinics provide a wide range of services including adult and child psychiatry, behavioural therapy, family therapy, marital counselling, speech therapy, etc. The services may be provided within a clinic setting or in a client's home, in schools, nursing homes, correctional centres or local general hospitals.

The effectiveness of this programme will depend on the numbers and competence of staff, their acceptance by the community (in particular by the professional community) and by their access to the Intramural system (hospital beds).

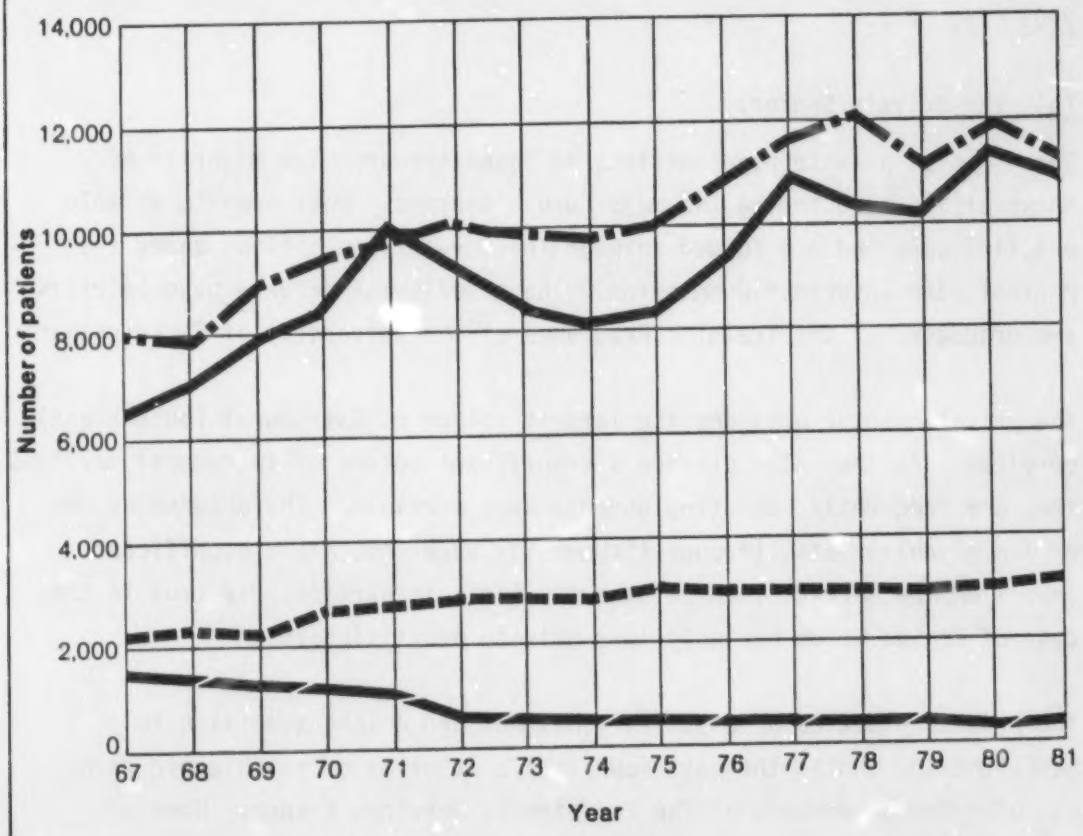
The Extramural Service is the backbone of the regionalized mental health system. The regionalization of services assumed that all Saskatchewan citizens would be guaranteed equal access to the major components of the mental health system. Except for a few special cases where scarcity of resources would prevent these being available in places other than the two major centres, our citizens could expect the same level of care and services regardless of where they live.

Submissions received by the Task Force would suggest that the government services have great difficulty in meeting these objectives. This has been attributed to severe restrictions on programme development and difficulties in recruiting and retaining staff due to fiscal restraint. Criticisms of this system related to the absence of services (e.g. children and youth, services to the elderly) as well as to lack of continuity in programming due to frequent personnel changes.

The successful shift in emphasis from institutional to community care is reflected by the increase in the number of community clients seen by Psychiatric Services programmes (fig.#1). This increase has been paralleled by a steady decrease in the average daily census for all inpatient facilities.

FIGURE #1

Figure10. Changes in Psychiatric Service Patterns In Saskatchewan Between 1967 and 1981



Code:

- Total Community Clients
- Total Community Contacts Divided by Ten
- Total Admissions to All Psychiatric Facilities
- Inpatients: Average Daily Census

Projections made by the Psychiatric Services Branch predict an increase in service utilization will significantly outstrip the increase in population. This increased utilization will be caused by an increase in the total population, the middle aging of the population, increased urbanization and the increase in utilization of services. It is anticipated that there will be a 43% increase in clients, from 13,585 in 1977 to 19,439 in 2001 (fig. #2).

(b) The Private Sector:

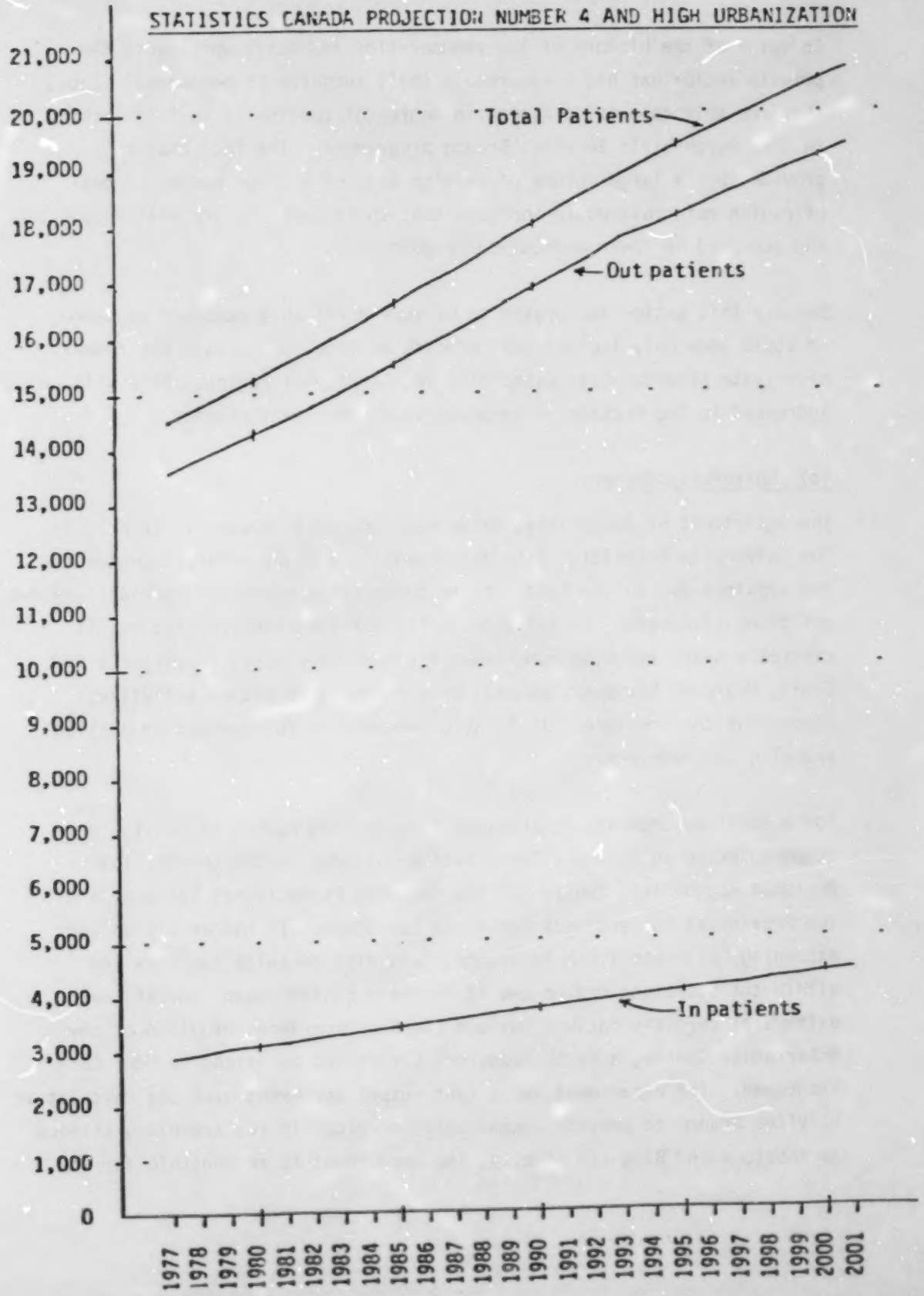
There are 11 private psychiatrists in Saskatchewan. The majority of these are located in the two major urban centres. Most operate as solo practitioners and are funded through fee-for-service billing under the Medical Care Insurance Commission. The majority of private psychiatrists are graduates of the Training Programme of the University of Saskatchewan.

The private sector provides the largest volume of Extramural (outpatient) services. As they also provide a significant volume of Intramural services, they are frequently operating under a huge workload. The absence of one or two psychiatrists, through sickness or vacation, has a significant impact on the service load on others. (This is particularly true in the case of Regina which has only four private practitioners.)

The private practice of psychiatry has not had a long tradition in Saskatchewan. Until the past few years a majority of psychiatric care was provided by members of the Psychiatric Services Branch. However, with the opening of the Medical School and its Residency Training Programme, there has been a slow but steady increase in the number of private psychiatrists in the province. Until recent years, this group of specialists suffered from a low fee schedule. This has only recently improved. The relatively poor financial reward, plus the heavy work burden, has not presented an attractive model to medical students looking for a future career.

FIGURE #2

PSYCHIATRIC SERVICES BRANCH
PROJECTED NUMBER OF CASES --- 1977 to 2001



In spite of the history of low remuneration and heavy workloads, the private sector has had a remarkably small turnover in personnel. Thus, they are able to provide a certain degree of continuity that is lacking in some Psychiatric Services Branch programmes. The fact that they provide such a large volume of service and see a large number of out-of-region referrals would indicate that their services are well recognized and accepted by their medical colleagues.

Because this sector has proven to be such a reliable manpower resource, it would seem only logical that efforts be made to increase the number of private psychiatrists especially in the City of Regina. This will be addressed in the section on Manpower in a subsequent chapter.

(c) University Sector:

The Department of Psychiatry, University of Saskatchewan, is located in the University Hospital. This department is a major referral centre for the province due to the fact that it possesses a number of special services not found elsewhere. In addition to its service responsibilities, it carries a heavy teaching commitment for Undergraduates, Psychiatric and Family Medicine Residents as well as continuing education activities throughout the province. It is also responsible for conducting applied and clinical research.

For a small department, it provides a surprising number of service programmes including Forensic Consultative services to the courts, the Regional Psychiatric Centre of the Canadian Correctional Service, and the Provincial Correctional Centre in Saskatoon. It has an active and expanding Child and Youth Programme, providing consultative services within the Saskatoon region and to Northern Saskatchewan. Additional extramural services include Day and Evening Programmes provided at the McKerracher Centre, a Youth Resources Centre and an extensive Home Care Programme. The department has a contractual agreement with the Psychiatric Services Branch to provide consultative services to run traveling clinics to Rosetown and Biggar. Finally, the department is responsible for the

provision of psychiatric consultative services to the Student Health Centre on the University of Saskatchewan Campus.

There are nine full-time (tenured) faculty members in this department. This represents the smallest academic department in Canada. On the other hand, it carries a service load which is unquestionably the largest of any academic department in the country. These two facts have drawn criticism by accreditation bodies who feel that too much was being asked of too few people.

Like their counterparts in the Private Sector, the members of the University Sector provide a significant amount of outpatient service to out-of-region patients. Also like the majority of their Private Sector counterparts, the heavy referral practise has resulted in long waiting periods for appointments.

The seemingly uncountrollable service demands have significantly interferred with the development of Residency Training and Research Programmes in this department. This in turn has had a significant effect on resident education and, particularly, on the recruitment of Saskatchewan Graduates to the programme.

An important component of the Department of Psychiatry is its Division of Psychology. This Division provides service to the Department of Psychiatry as well as to other programmes within the hospital and the community. Consultative services are provided to University Hospital Pain Clinic as well as to the Departments of Orthopedics, Medicine, Pediatrics, Rehabilitation Medicine, Children's Rehabilitation Centre and the Burn Unit. In addition to these service responsibilities, the staff of the Division carry a heavy teaching lead in the Medical School and the Campus Department of Psychology. This Division has recently instituted a Clinical Internship Programme for students at the Masters degree level.

The University Hospital Psychiatric Home Care Programme was started in 1961 as a demonstration project. Initially it consisted of a half-time nurse. Since then it has grown into a programme with 12 nurses and an average patient census of 336. The programme is accessible to all general practitioners and psychiatrists within the City of Saskatoon. It provides essential treatment and support services including crisis intervention, which enables patients to be maintained in the community through direct patient care and family support. This reduces the pressure of the inpatient beds in the Saskatoon region.

SUMMARY:

The quality of Extramural Programmes varies greatly from region to region depending on the number and types of staff available. The two major urban centres have had the most success in providing a reasonable range of services which are readily accessible to all citizens. The other regions, however, had difficulty achieving this goal because of chronic fiscal restraints and the inability to maintain an adequate number of staff. These regional programmes appear to have been particularly vulnerable to difficulties in recruiting and retaining qualified staff and budget restraints resulting in the freezing of vacant positions. These factors have made it extremely difficult for many regions to provide continuity of care and in some instances continuity of programming.

One aspect of the Extramural Services that came in for universal praise was the Community Mental Health Nursing Programme. General practitioners, approved home operators, psychiatrists, relatives and patients, all were lavish in their praise of the competence and dedication of this group of mental health professionals. What continuity of care is available in many regions is due primarily to the presence of these nurses. Many of them, however, seem to be operating under heavy caseloads. Care must be taken to ensure that the staffing complement keeps pace with new responsibilities and increasing populations to avoid the possibility of burn-out.

All regions, including the two urban centres, have difficulty servicing the needs of the elderly and the natives. Saskatchewan, as yet, does not have a well developed psychiatric service programme for the elderly. Operators of nursing homes and extended care facilities complained about the difficulty in gaining access to psychiatric services. The problem in servicing the needs of the native population is addressed in another section of this report.

Extramural Services acting as they do as a buffer between the Community and Intramural sectors are a vital component of the mental health system. In the majority of regions in the province they have not, as yet, achieved the goal of providing a wide range of services to meet the needs of clients of all ages. In order that this sector of the mental health system can become fully operational, THE TASK FORCE RECOMMENDS:

15. THAT THE GOVERNMENT REAFFIRM ITS COMMITMENT TO THE REGIONALIZATION OF MENTAL HEALTH SERVICES TO ENSURE THAT ALL CITIZENS REGARDLESS OF AGE, CULTURAL BACKGROUND OR PLACE OF RESIDENCE HAVE EQUAL ACCESS TO A FULL RANGE OF MENTAL HEALTH PROGRAMMES.

16. TO ENABLE REGIONAL MENTAL HEALTH PROGRAMMES TO PROVIDE THE NECESSARY RANGE OF SERVICES THAT THE GOVERNMENT IMMEDIATELY PROVIDE FINANCIAL AND MANPOWER RESOURCES TO ACHIEVE THIS OBJECTIVE.

17. THAT PSYCHIATRIC SERVICES BRANCH IMMEDIATELY INITIATE PILOT PROJECTS IN URBAN AND RURAL REGIONS TO STUDY ALTERNATIVE MEANS OF MEETING THE UNMET SERVICE NEEDS OF CHILDREN & YOUTH, THE ELDERLY AND THOSE OF INDIAN ANCESTORY.

C. INTRAMURAL LEVEL OF CARE:

The Intramural System includes all the psychiatric inpatient beds providing 24-hour care in a protective environment for individuals who because of disability arising from mental disorder are unable to be adequately treated in the community. This excludes general hospital beds that are not in Psychiatric Units.

Prior to the regionalization of the Psychiatric Services Branch programmes, most psychiatric treatment was provided in the two major mental hospitals. (Munroe Wing of the Regina General Hospital did have a small Unit of under 30 beds.) At one time the combined patient population for the two major mental hospitals was 4,500. This gave Saskatchewan the dubious distinction of having the highest ratio of institutionalized citizens in the country.

Since 1955, with the opening of the psychiatric units in Saskatoon and Moose Jaw and with the implementation of the Saskatchewan Plan, there has been a gradual shift from mental hospital care to regionalized inpatient services. Inpatient facilities can now be found in all eight mental health regions. They exist as wards in general hospitals or as independent Psychiatric Units adjacent to regional hospitals.

There are eleven Psychiatric Inpatient Facilities in Saskatchewan. The largest is the Saskatchewan Hospital at North Battleford which houses approximately 200 long-term patients. Of the remaining ten facilities, six are operated by the Psychiatric Services Branch of the Department of Health. The four remaining units are located in four general hospitals in Regina and Saskatoon. These are operated by their respective Hospital Boards. The funding for these Units comes from the Saskatchewan Hospital Services Plan.

Where Saskatchewan once had the highest number of psychiatric beds, it now has one of the lowest bed ratios of any jurisdiction in Canada. The average number of beds is 3.33/10,000 population. This compares with a national average of 9.0/10,000. The bed ratio in Saskatchewan varies from region to region, ranging from 5.34/10,000 in the Yorkton region to 2.08/10,000 in the Saskatoon region.

The reductions in the number of people in the Intramural System has been achieved by a variety of measures. These include early diagnosis and treatment leading to a reduction in median length of stay as well as by an

increasing number of patients being treated in general hospital beds. The total number of beds have been reduced from a high of 3,771 in 1964, to 702 in 1981. There are some indications, however, that we may have reached the limit to which the Intramural System can be reduced. Psychiatrists in Saskatoon, and to a lesser extent in Regina, informed us that the lack of available beds has necessitated psychiatric emergencies to be transferred out-of-region or to remain in the community until a vacancy occurs. Neither option is desirable. Patients in all regions should have the right to be treated within that region. On the other hand, the practise of attempting to keep extremely ill patients at home carries with it considerable risks to the patients and undue hardship for the families. Although Regina has been successful in providing in-patient services to all within their catchment area, Saskatoon (with a lower bed ratio) has had to refer emergency cases to the regional psychiatric facility at Prince Albert. Recent figures report an increase in the number of such referrals from 18 in 1981-82 to 37 in 1982-83.

The four units in the two urban centres operate with a very high average daily census. High occupancy levels are not conducive to good quality of care. Psychiatrists report that faced with this problem plus the increasing pressures for admission, they are all too often forced to discharge patients before they are ready. Unfortunately this frequently leads to a recurrence of their condition and subsequent readmission.

The following figures would indicate a certain maldistribution of inpatient facilities. Whereas Saskatoon, Regina and Swift Current have less than the average **number of beds, Yorkton and Weyburn have an over-supply.

Facility	Population	Beds	Bed Ratio*
Saskatoon	264,787	55	2.08
Regina	203,871	60	2.94
Swift Current	50,220	14	2.79
Yorkton	87,999	47	5.34
Weyburn	80,464	40	4.97

* Based on 10,000 persons.

** Average = 3.3/10,000.

Population projections would suggest that the proportion of elderly in our population will increase steadily, thus placing greater demands on Intramural Services. This fact plus any improvement in services to children, youth and the native population could also have significant impact on Intramural Services, particularly in the two major urban centres where most tertiary care programmes are located. It is clear that although the system does not require the massive number of beds it once had, nonetheless, certain areas, particularly Saskatoon and Regina, are in need of additional beds to meet current demands. To correct these deficiencies, THE TASK FORCE RECOMMENDS:

18. AN IMMEDIATE REVIEW OF INTRAMURAL SERVICES IN SASKATOON AND REGINA TO IDENTIFY THE NUMBER OF BEDS REQUIRED TO MEET CURRENT AND FUTURE NEEDS OF THE RESIDENTS OF THESE TWO CATCHMENT AREAS.

Over the long term the most likely source of relief for the Intramural System would be through the provision of additional Level IV Care beds in each region and the establishment of a spectrum of residential services and community support programmes.

The Task Force was appraised of the existence of a number of "problem" patients who do not fit comfortably into existing inpatient facilities. Although the exact number of such patients is not known, it is generally agreed that they represent a relatively small number. However, what they lack in numerical size they more than make up for in the amount of time and energy that has to be invested in them by mental health and social service personnel. With the increasing demands placed on existing inpatient services these individuals are not well tolerated as inpatients. As noted in another section of this report (Law and the Mentally Disordered), conflicts arise as to whether they rightly belong in the health or criminal justice system. The Task Force was aware that this small number of chronically ill, noncompliant patients have led to demands from some sectors of the community for the reopening of the Mental Health Hospital at North

Battleford. Although the members of the Task Force had sympathy for those recommending this solution, they were not convinced that all reasonable alternatives had been given a fair trial. On the other hand, we were not convinced that either the government or the Psychiatric Services Branch had responded quickly enough to these concerns. The Task Force sensed a growing impatience with the lack of activity by the Branch in addressing this issue.

While the Task Force could not agree that the answer to this problem was the reopening of the Provincial Hospital at North Battleford, it did feel that unless some plan of action is forthcoming in the near future, the government may be forced into the position of conceding to these demands. For this reason, THE TASK FORCE STRONGLY RECOMMENDS:

19. THAT THE PSYCHIATRIC SERVICES BRANCH GIVE TOP PRIORITY TO DEVELOPING AND IMPLEMENTING A PLAN TO MEET THE GROWING PROBLEM OF THE HARD-TO-MANAGE PATIENT IN THE COMMUNITY.

SUMMARY:

Saskatchewan has achieved partial success in the phasing out of the mental hospital with the implementation of a regionalized intramural system. Until recently, the major problems in respect to inpatient services were chiefly related to the difficulties in recruiting and retaining psychiatric consultants. Over the past two years there would seem to be a gradual increase in the demands for beds, particularly in the Saskatoon Catchment Area. It would appear that for the moment we have reached the lower limit of bed capacity; in fact, in the Saskatoon region we have probably gone beyond this point. In order to protect the Intramural System from excessive demand, it is obvious that strengthening of the Extramural and Community Systems is indicated.

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V COMMUNITY SERVICES

This section of the Report directs itself to the examination of those non-medical services formerly provided by the asylum which now under a community-based service system are established in the community. These services include shelter, vocational rehabilitation, socialization activities and income support.

The Report will describe the existing community mechanisms for supplying these services under the following headings:

A. Residential programmes
B. Vocational programmes
C. Social and Recreational programmes
D. Income Support

A. RESIDENTIAL PROGRAMMES:

A recent survey by Mental Health Saskatchewan indicated that the majority of psychiatric patients return to their homes after discharge from hospital. Many of these in a relatively short time will be able to return to independent activity. Others, whose condition while stabilized and thus not requiring inpatient care, will not yet be ready for fully independent living. Until full recovery is achieved or they have attained their optimum level of functioning, this group will continue to require varying types and levels of support in order to be maintained in the community. Failure to meet these needs will increase the risk of "social breakdown" and eventual readmission to hospital.

In the previous chapter we referred to a small group of patients who, although not requiring inpatient treatment, are unable to function independently in the community. Frequently these people are without family or community supports but on the other hand, are unwilling or unable to accept help from social agencies or mental health programmes. They do not fit comfortably into standard boarding houses nor, indeed, hotels for transients. As a result they tend to move from place to place.

Because of their non-compliance with treatment programmes, poor personal and financial management, bizarre or disruptive behaviour, they frequently present as a social crisis resulting in the involvement of the police, social agencies or the emergency services of general or psychiatric hospitals. Although these "crisis" states are not true medical emergencies, neither do they justify criminal justice procedures; yet, frequently these are the only alternatives available with the result that these individuals find themselves in a psychiatric unit or in the police cells. Clearly, there is the need for a more practical alternative than using scarce hospital beds or police facilities for what essentially is a hosteling function.

Saskatchewan has taken some pride in the fact that it has reduced the number of institutional beds and that it has managed to operate with one of the lowest bed ratios in Canada. A number of submissions pointed out that this relative scarcity of beds has resulted in increasing difficulty in admitting very sick individuals. Psychiatrists, in particular, pointed out that an increasing number of sick individuals are having to be maintained in the community for varying lengths of time until beds become available. They suggest that this poses two risks: (a) to the patients themselves, and (b) the family experiencing burn-out. (These concerns about coping with sick family members were also raised by relatives of patients). What this amounts to is a shifting of the burden for care of acutely ill patients from inpatient facilities directly to families, approved home operators, etc. In order to provide support to these "supporters", some mechanism must be found to provide relief when admission of patients is not immediately available. The provision of a "respite" service would serve not only to relieve the immediate burden on the family but help to maintain their commitment to providing continuing care for the affected member. (This has particular relevance in terms of the elderly.)

In reviewing the existing residential situation in Saskatchewan, the Task Force identified four classes of residential options open to individuals incapable of fully independent living:

(a) Approved homes

(b) Group homes
(c) Special Care homes
(d) Unapproved homes

(a) Approved Homes

An approved home is a family home that may be licensed under the regulations of the Mental Health Act to provide a supportive residential environment in the community for a maximum of six individuals requiring assistance in daily living. According to the Annual Report of the Department of Health, "these homes are reviewed periodically to ensure acceptable standards of accommodation and care". Approved homes are available both for clients of the Psychiatric Services Branch and Core Services (mentally retarded). These homes are located in all mental health regions and are under the supervision of the Regional Psychiatric Services Unit. As these are private homes, they vary greatly in terms of physical standards although all having to meet certain minimum standards as set down in the Act. The knowledge and skills of the operators of these approved homes also vary considerably, depending on their background and experience. Many have formerly worked in the mental health system and so bring to their home a good deal of experience in the management of individuals with chronic mental disability. Others are untrained and inexperienced. It was noted that operators have formed a Provincial Association and in several regions have organized Regional Associations to provide their own inservice education. However, this is voluntary and not mandatory. Finally, many operators complained about the lack of access to vocational rehabilitation or socialization programmes for their guests. Many operators attempt to provide some recreational outlets, but are understandably limited in what they can offer. It would appear, from the submissions made by approved home operators and from mental health professions (particularly those in the rural regions), that this residential facility plays an essential role in our mental health system. As in any system there are a few operators who fall short of expectations, but it would appear that the majority of operators are highly motivated and strongly committed to the welfare of their clients.

In looking at the Approve Home programme, most mental health workers and approved home operators agree on certain basic needs: (i) more field staff in the mental health regions to provide closer liaison and supervision; (ii) formal training programmes for prospective approved

home operators and formal continuing educational programmes for those already in existence; (iii) the need for regionalized vocational rehabilitation and socialization programmes for their guests.
THE TASK FORCE RECOMMENDS:

20. THAT THE APPROVED HOME PROGRAMME SHOULD CONTINUE TO PROVIDE THE BACKBONE OF RESIDENTIAL SERVICES IN THE COMMUNITY.

21. THAT APPROVED HOMES BE MAINTAINED AND STRENGTHENED THROUGH IMPROVED SUPERVISION AND MONITORING OF THE QUALITY OF PROGRAMMES WITHIN THE HOMES.

22. THE ESTABLISHMENT OF A MANDATORY TRAINING PROGRAMME FOR ALL PROSPECTIVE APPROVED HOME OPERATORS.

(b) Supervised Group Homes:

The Department of Health's Annual Report describes these as homes established by a community volunteer board in order to offer a high staff/client ratio treatment programme within a family-type dwelling. These homes are for clients who require continuing involvement with mental health professionals. The group home represents a higher level of care than exists in approved homes.

The underlying philosophy of these group homes is that they be community-based and operated. This, of course, is consistent with the "normalization" approach which envisages that clients receive services in settings as close to "normal" as is possible. In so doing, it is expected that they will not be identified as belonging to an institution and thus would blend into the surrounding community. The group homes are selected on the basis of their ability to meet this criteria on physician and programmatic grounds.

In order to ensure that the home is not just in the community but of the community, it is hoped that "volunteers" representative of the community at large would band together to establish a society which would run such a home.

To date, eleven such group homes have been established within the province. By any yardstick this is an inadequate number. Professionals within and outside the Psychiatric Services Branch, as well as relatives and other concerned groups, express the need for a significant increase in the numbers of this type of residential facility. Although specific data was not provided as to the number of clients who could be appropriately placed in this type of community, educated guesses from those in the mental health field would indicate that doubling of the current number would certainly be indicated. THE TASK FORCE RECOMMENDS:

23. THAT URGENT ATTENTION BE GIVEN TO THE NEED FOR ADDITIONAL GROUP HOMES AND SPECIFICALLY THAT THE NUMBER BE INCREASED TO TWENTY WITHIN THE NEXT TWO YEARS.

In the course of its deliberations, the Task Force learned that many so-called "societies" running group homes are, in fact, made up on employees of the Psychiatric Services Branch or the Department of Social Services. It is obvious that without the commitment of these concerned civil servants we would not be blessed with even the few group homes we have today. However, it is also obvious that if this trend continues, group homes will never be seen as a community endeavour but simply another government programme dropped into the neighbourhood. This can only heighten the resistance to the introduction of these programmes into the community.

There is some logic in expecting the Psychiatric Services Branch to establish and operate group homes. Afterall, the main thrust of deinstitutionalization was not simply the closure of beds but the relocation of resources and funds to community programmes. The fact that this has not been done (and the budgets for the last ten years are ample proof of this) could be seen as justification for insisting that the Psychiatric Services Branch complete the second phase of deinstitutionalization by establishing and operating residential programmes within the community. The Task Froce was concerned, however,

that this would be counter to the "normalization" approach. Certainly other government health programmes (specifically those within the Alcohlism Commission) provide examples of community initiated residential treatment programmes that have evolved in response to demonstrated community needs. These have been initiated and operated by the community itself through a lay board of management. THE TASK FORCE RECOMMENDS:

24. THAT THE MENTAL HEALTH ASSOCIATION IN SASKATCHEWAN IDENTIFY THOSE COMMUNITY LEADERS WHO COULD BE INDUCED TO CO-ORDINATE A COMMUNITY RESPONSE TO THEIR CONTINUING RESIDENTIAL NEEDS, WITH THE EXPECTATION THAT THE PSYCHIATRIC SERVICES BRANCH WOULD ASSIST THESE LEADERS IN THE DEVELOPMENT OF THESE PROGRAMMES.

(c) Special Care Homes:

A significant number of guests in special care homes in the province exhibit varying degrees of emotional disorder. In a majority of instances these are managed successfully in that their "guests" are able to remain within the facility without requiring transfer to a psychiatric unit. The quality of care, however, must be open to question. Submissions from nursing home operators would indicate a dearth or lack of psychiatric consultative services, the absence of inservice education, and a lack of personnel trained to cope with emotional crises. The main medical resource remains the general practitioner. The degree of the GP's involvement in mental health problems of nursing home clients may depend on the ability of the nursing staff to identify emotional disorders, the availability of psychiatric consultative services and the level of communication between the practitioner and the mental health system. The need for better psychiatric services to special care homes was identified by all sectors of the health system. Furthermore, there is a need for inservice education for nursing home staff to enable them to identify and more effectively manage guests with emotional problems.

A special issue raised was that of those Level IV patients whose behaviour is seen as disruptive, frightening or troublesome. As noted earlier, many of these patients end up in psychiatric units where they tend to be long-stay residents. Although many of them are quickly stabilized and soon ready for discharge, they find their place in the Level IV Home has been filled. The Task Force Committee was aware that this is a longstanding problem and the cause for a great deal of acrimonious debate between members of the psychiatric profession, general practitioners and nursing home operators.

The Task Force feels that it is important to develop programmes to meet the needs of nursing homes to enable early identification of psychiatric problems and thus early intervention. This should obviate the necessity to admit many of these guests to psychiatric units.
THE TASK FORCE RECOMMENDS:

25. THAT PSYCHIATRIC SERVICES BRANCH ESTABLISH, ON A REGIONAL BASIS, CONTINUING EDUCATION PROGRAMMES FOR SPECIAL CARE HOME OPERATORS AND STAFF.

26. THAT THE DEPARTMENTS OF GERIATRIC MEDICINE AND PSYCHIATRY, OF THE COLLEGE OF MEDICINE, ESTABLISH A GEROPSYCHIATRIC CONSULTATIVE SERVICE AS A DEMONSTRATION PROJECT.

(d) Unapproved Homes:

Because of the lack of an adequate number of approved home placements or because of the inability of patients to fit into these homes, many clients/patients live in "unapproved" boarding homes, apartments or hotel rooms. This has been the source of a great concern, particularly to social workers and community psychiatric nurses. The low standard of housing, the untherapeutic milieu and the total lack of direction to their clients' daily existence were common criticisms of unapproved homes. These conditions tend to lead to withdrawal, regression and a loss of any gains made from prior treatment. All too often the final outcome is social breakdown

leading to a "crisis" and subsequent readmission to an acute care unit for stabilization. This group of clients and this particular situation are examples of the revolving door syndrome. This represents not only inefficient use of resources but has a negative impact on the morale of the patients and treatment personnel alike.

On the basis of submissions to the Task Force and from reviews of the literature, there would appear to be a need in Saskatchewan for three levels of residential facilities to provide sufficient support for patients being treated in or returning to the community:

1) Temporary housing
2) Transitional housing
3) Indefinite residence

1) Temporary Housing:

Community mental health workers as well as those manning psychiatric emergency services identified the need for short-term shelter for those individuals who may be in acute distress or social breakdown but for whom temporary removal from the environment may be all that is required. The cause of the "breakdown" may be marital, family/landlord conflicts, or work related.

This programme would provide shelter and supervision anywhere from a few hours up to a few days. Thus, it could serve a variety of functions including a haven for short-term social dislocation, a residence where the client may receive medical treatment and supervision, or a respite centre for short periods of time for those individuals who because of illness or other disruption in the family are unable to remain in the home. This service could be provided in family homes, approved homes, supervised apartments and in nursing homes. It would enable the resolution of social crises as well as the stabilization of acute medical problems without having to admit the client to an inpatient facility. Heretofore many of these clients have been admitted to acute care beds on humanitarian as opposed to medical grounds. This was an inappropriate and inefficient use of scarce resources.

Models for such temporary housing already exist; e.g. Southwest Denver Community Mental Health Services.

2) Transitional Housing:

This type of housing is indicated for individuals involved in various training or upgrading programmes following discharge from an acute care unit. This housing is indicated for those clients who while not requiring inpatient care, are not yet capable of totally independent living. It is usually restricted to clients who exhibit the potential for improving their level of functioning through the acquisition of vocational and social skills. This type of residence would include:

(a) Supervised Apartments - i.e., a community-based residential programme having one or two staff members who supervise and teach daily living skills to clients located in several apartments in a city, town or village.

(b) Supervised Group Homes - i.e., a community-based group living facility providing room and board and supervision in daily living skills for persons in need of long-term rehabilitation.

(c) Transitional Apartments/Community Residences - i.e., community-based residences operating 24 hours a day and providing an intensive training in daily living skills as well as room and board.

(d) Apartments in Group Homes with Behavioural Emphasis
This would include group apartment programmes for clients with serious behaviour problems (e.g. self-destructive or disruptive behaviour). The programme within this residence would be designed to replace problematic behaviours with appropriate living skills. The expectation would be that these clients would move into a less restricted environment.

(e) Apartments and Group Homes with Physical Care Components and Behavioural Emphasis - for clients who require both intensive

behavioural as well as physical programme intervention directed at assisting with activities of daily living.

These residential alternatives do not represent innovative ideas. Examples of all of these can be found in other parts of this country and the United States. The Fountain House Organization in New York City is a recognized leader in the development of transitional housing programme. In Canada, the Hari Organization of Calgary has been very active in the establishment of supervised apartments and group homes. Similar organizations also exist in Vancouver.

Because of our unique problems of population and geography it may be inappropriate to attempt to duplicate model programmes that exist in densely populated metropolitan centres elsewhere; however, programmes incorporating the general principles could be established in Saskatchewan.

3) Indefinite Residence:

One of the recurring complaints the Task Froce heard related to the lack of residential facilities for those individuals who because of continuing disability are unable to live in the community without a social supportive living group or who if left to their own devices would end up living an isolated existence in a room in a third-rate hotel or an unapproved home. We were not provided with documentation as to the exact number of clients who would need this kind of housing. It was apparent, however, that they exist in sufficient numbers and have caused considerable concern to families in the community, as well as community and provincial agencies, to establish that there is a need for some urgency in addressing this increasing problem. It was in respect to this particular group of clients that the recommendation of "reopening" the mental hospital usually arose. The Task Force, while not agreeing that this was the idea nor even the desirable solution, was in agreement with the proposition that this particular issue should be given a high priority. Accordingly, THE TASK FORCE RECOMMENDS:

27. THAT THE GOVERNMENT OF SASKATCHEWAN GIVE A TOP PRIORITY TO THE DEVELOPMENT OF A SPECTRUM OF RESIDENTIAL ALTERNATIVES RANGING FROM TEMPORARY TO INDEFINITE RESIDENCES.

28. THAT THE GOVERNMENT OF SASKATCHEWAN PROVIDE GRANTS TO COMMUNITY GROUPS TO ESTABLISH RESIDENTIAL PROJECTS IN BOTH RURAL AND URBAN SETTINGS.

B. VOCATIONAL REHABILITATION:

The majority of individuals admitted to a psychiatric facility for the first time have maintained relatively steady employment prior to admission. Many of these upon recovery from their illness return to their previous work or employment. A minority, however, because of the disabling effects of long-term illness or indeed the institutionalization effect of "long term treatment", show an impaired ability to gain and maintain employment. The effect of this plus the loss of social skills puts them at considerable risk for "social breakdown". Their ability to cope with the ordinary issues of everyday life may become increasingly impaired and this may end up in a social "crisis". This, of course, frequently leads to readmission to hospital and a repetition of the cycle described earlier. It is expecting too much of individuals so incapacitated to make the abrupt change from the protective environment of an inpatient unit to the relative independence of a placement in the community. It is recognized and accepted that no community support programme for such patients is complete without well designed vocational and socialization components.

In the traditional mental hospital there was a wide spectrum of vocational activities ranging from pre-vocational to vocational training and sheltered work programmes. In the transfer of these mental hospital functions to the community (as a part of the deinstitutionalization programme) it was anticipated that patients might use existing programmes within the community including the sheltered workshop available to the mentally and physically disabled. This would be consistent with the "normalization" approach.

A position paper by the Mental Health Association of Saskatchewan, published in February, 1982, pointed out that of 1,142 people of working age on the

Psychiatric Services Branch caseload who were unemployed as a result of psychiatric disability, only 175 were involved in a sheltered workshop or activity centre (fig. 1). This study supports the impressions of a large number of submissions that complained about the lack of or absence of adequate vocational rehabilitation programmes across the province. Most of these complaints came from mental health workers and approved home operators in rural areas. However, workers in the large urban centres were equally critical of vocational rehabilitation services for psychiatric patients. Again, the lack of services should not be taken as evidence that these programmes do not exist elsewhere. The Fountain House Organization in New York City has pioneered in this area. This led to a proliferation of similar programmes across the United States. Yet apart from some recent initiatives in the Regina catchment area, it is safe to say that the Task Force failed to find any systematic approach or programme for vocational rehabilitation services for this sector of our population.

Once again, the Task Force recognizes that model programmes which have been established in highly industrialized metropolitan centres such as New York, Vancouver and Toronto, cannot necessarily be duplicated in toto in Regina and Saskatoon, let alone Yorkton, Swift Current, Melfort, etc. We do feel, however, that the time is long overdue for some initiatives in the form of pilot or experimental programmes in both rural and urban settings in Saskatchewan. THE TASK FORCE, ACCORDINGLY, RECOMMENDS:

29. THAT A HIGH PRIORITY BE GIVEN TO THE ESTABLISHMENT OF EXPERIMENTAL PROGRAMMES IN VOCATIONAL REHABILITATION TO INCLUDE PRE-VOCATIONAL, VOCATIONAL AND TRANSITIONAL EMPLOYMENT COMPONENTS.

C. SOCIALIZATION PROGRAMMING:

This involves any activity aimed at increasing an individual's capacity for interpersonal involvement in social and recreational situations. The critical aspect of this activity is creating the opportunities for the clients to acquire the interpersonal skills which will increase their social

(fig. 1)

NUMBER OF PERSONS DISABLED BY MENTAL ILLNESS

Region	Standard Age Group			Total	Number in		Number not in either Activity Centres or Sheltered Workshops
	19-29	30-44	45-65		Activity Centres	Sheltered Workshops	
North Battleford	22	25	33	80	0	19	61
Weyburn	4	13	25	42	2	25	15
Regina	83	98	115	296	2	12	282
Saskatoon	89	62	71	222	42	11	169
Moose Jaw	34	35	60	129	0	6	123
Yorkton	14	33	52	99	0	8	91
Prince Albert	73	68	81	222	28	*	194
Swift Current	14	21	17	52	20	*	32
Total	333	355	454	1142	94	81	967

These totals pertain to clients who are or have been:

1. on the case load for more than one year
2. unemployed
3. diagnosed as schizophrenic or having organic brain damage or an affective disorder

Source: Psychiatric Services Branch, Saskatchewan Health (it should be noted that these figures underestimate the number of psychiatrically disabled people because psychiatrically disabled people who see private practice psychiatrists or family physicians are not included in these figures unless they are also on the Psychiatry Services Branch caseload.)

* In these towns and cities, the Activity Centre and Sheltered Workshop are housed in the same building, and for this study the number of clients are counted together.

appropriateness and social integration. In the mid-1960's, with the push for the reduction in the size of our two mental hospitals, it was recognized that many chronic patients had lost many of the most basic social skills that were necessary in adjusting to normal community life. This led to the development of a variety of programmes that would train or retrain patients in order that the problems of adjusting to semi-independent or independent existence could be reduced.

With deinstitutionalization it was expected that these programmes would also be relocated in the community again with the emphasis on using existing community social resources in keeping with the normalization approach. The responsibility for the establishment and operation of these programmes was taken over by the Mental Health Association in return for grants from the Psychiatric Services Branch. A series of White Cross Centres were established throughout the province. In recent years they have been replaced by "community service centres" which are located in North Battleford, Moose Jaw, Regina and Swift Current. These centres provide social and recreational opportunities for "emotionally troubled" people. In other centres (specifically Estevan, Regina, Saskatoon, Weyburn and Yorkton) the local Mental Health Associations utilize existing community resources to provide these programmes. In the paper "Mental Health and Rehabilitation", published in January, 1980, the Mental Health Association of Saskatchewan identified 307 clients who were being served by these six programmes. In their report, however, they acknowledged their inadequacy in terms of reaching all in need and in providing adequate staffing to carry out the programme objectives.

The Task Force commends the efforts of the Mental Health Association to meet the important needs of those patients who lack basic life skills. The lack of adequate staffing and funding has seriously hampered the effectiveness of this programme. The Task Force feels that to attempt to operate these programmes under current conditions constitute a considerable disservice in that it will only sustain the illusion that this important component of rehabilitation is being addressed. Clearly, this programme needs strengthening and this can be done only with an infusion of funds. The

Mental Health Association must review its position with respect to this programme. The options are: (1) to carry on as is; (2) to seek more funds from government; (3) failing #2, to withdraw from this field of activity and devote the scarce resources to patient advocacy activities.

D. INCOME SUPPORT:

It was brought to the attention of the Task Force that most of the clients who presently reside in approved homes, group homes and in special care homes are on the social assistance programme support. The amount of money available to these clients for spending money, clothing and recreation is extremely limited. Clients currently living in approved homes receive a monthly clothing allowance of $10, with $35 for comforts and $19 for transportation costs when required. These funds are clearly inadequate. They present a very real obstacle in the way of normalization. Clearly, support for this group of patients should be re-examined. THE TASK FORCE RECOMMENDS:

30. THAT GOVERNMENT POLICIES REGARDING COMFORTS ALLOWANCE FOR MENTALLY ILL PATIENTS ON SOCIAL ASSISTANCE BE REVIEWED.

31. THAT A MINIMUM INCREASE OF 25% OF THE CURRENT ALLOWANCE SHOULD BE INITIATED IMMEDIATELY.

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VI (A) SPECIAL GROUP SERVICES AND NEEDS

1. The Rights of the Child

There is general agreement in our society that children need special protection and privileges (such as the right to education and the right to freedom from exploitation and abuse). Yet many children in this province do not receive the protection and security they need for their optimal development. Among these inadequately protected children are some who are disabled and some who are from families disadvantaged by poverty, isolation or illness. These children are at special risk of developing problems in their mental and physical health and their later adjustment in society.

The report of the Saskatchewan Council on the International Year of the Child sets forth the United Nations Declaration of the Rights of the Child. This declaration of rights is reproduced in Table I.

As the most basic step toward promotion of the mental health of the province's children, our most valuable natural resource, THE TASK FORCE RECOMMENDS:

32. THAT THE PROVISIONS OF THE UNITED NATIONS DECLARATION OF THE RIGHTS OF THE CHILD BE INCORPORATED INTO SASKATCHEWAN HUMAN RIGHTS LEGISLATION.

Table 1

Declaration of the Rights of the Child

Whereas the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights, and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom.

Whereas the United Nations has, in the Universal Declaration of Human Rights, proclaimed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

Whereas the need for such special safeguards has been stated in the Geneva Declaration of the Rights of the Child of 1924, and recognized in the Universal Declaration of Human Rights and in the statutes of specialized agencies and international organizations concerned with the welfare of children.

Whereas mankind owes to the child the best it has to give.

Now therefore,
The General Assembly
Proclaims this Declaration of the Rights of the Child to the end that he may have a happy childhood and enjoy for his own good and the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals and upon vuluntary organizations, local authorities and national Governments to recognize these rights and strive for their observance by legislative and other measures progressively taken in accordance with the following principles:

Principle 1

The child shall enjoy all the rights set forth in this Declaration. All children, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

Principle 2

The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose the best interests of the child shall be the paramount consideration.

Principle 3

The child shall be entitled from his birth to a name and a nationality.

Principle 4

The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end special care and protection shall be provided both to him and to his mother, including adequate pre-natal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.

Principle 5

The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

Principle 6

...hild, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of State and other assistance towards the maintenance of children of large families is desirable.

Principle 7

The child is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture, and enable him on a basis of equal opportunity to develop his abilities, his individual judgement, and his sense of moral and social responsibility, and to become a useful member of society.

The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents.

Principle 8

The child shall in all circumstances be among the first to receive protection and relief.

Principle 9

The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form.

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

Principle 10

The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among people, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

2. Overview of Mental Health Problems of Children & Youth

Mental health problems of children and adolescents may be defined from many points of view, including those of the parent, the educator, the police and courts, social service workers, physicians, psychiatrists and clinical psychologists. From the point of view of the parent, a child who is unhappy, unco-operative, socially isolated, or destructive may be seen as having mental health problems From the point of view of the educator, children with learning deficits due to cultural deprivation and children with sensory, physical, perceptual or emotional problems that impede learning may be seen as having mental problems. From the point of view of the police and courts, children who are judged to be delinquent may be included. From the point of view of social service workers, the abused, neglected or abandoned child is included. From the point of view of the family physician, the child with behavioural problems or disorders related to stress, such as disorders of sleep, eating, elimination of hygiene, is thought to show evidence of mental health problems. From the point of view of the psychiatrist and the clinical psychologist (Quay et al., 1979), mental health problems of children include four major types: (1) conduct disorder, manifested by aggressive behaviours associated with poor interpersonal relationships; (2) personality disorder, characterized by anxiety, distress and social withdrawal; (3) immaturity, as manifested by regressive behaviour characteristic of younger children; (4) socialize delinquency, seen in socially undesirable behaviour which is accepted in the peer group.

It is difficult to estimate the prevalence of mental health problems i young people, in part because of the multiplicity of possible definiti and in part because most affected children never come to the attention

mental health practitioners. In Saskatchewan, a 1968 survey asked teachers to complete questionnaires covering variables such as academic performance, behaviour, physical health and disability and home life. An unselected sample of 5,531 children in grades one to eight was included. The incidence of children identified as emotionally disturbed and in need of special programmes was 8.4 percent. The most comprehensive attempt in Canada in recent years to arrive at such an estimate was made in the CELDIC report (1970): "Perhaps the most we can say at the moment is that in any school age population in Canada, the probability is that somewhere between two and three percent of the children are in full-time special educational placements and that teachers, and others, express concern about a further eight to twelve percent of children whose problems in behaviour, self-management or learning are considered to need additional expert help both in and outside of school." In numerical terms, the CELDIC estimate would yield a Saskatchewan prevalence of 30,000 to 40,000 children needing special psychological or educational help.

In a recent Saskatchewan government report entitled "Saskatchewan Health for Children and Youth", the prevalence of various handicapping conditions is estimated for Saskatchewan, based upon prevalence figures provided by the United States Office of Education. The figures estimate a prevalence of approximately 7,000 children and youth in the "emotionally disturbed" category and an additional approximately 36,000 children and youth with various other handicapping conditions (i.e. speech impairment, mental retardation, learning disabilities, physical impairment, deafness and hearing impairment, visual impairment, multiple handicaps) who would be considered to have a high risk for the development of mental health problems. In total, according to this estimate, there are approximately 44,000 people under the age of 19 in need of special forms of assistance in order to optimize their development and mental health.

How many young people actually receive the assistance they need? Figures from 1974 indicate that although 39% of the population was under 20 years

of age, only 15½ of those receiving psychiatric services from all sectors were under 20 years of age. This suggests that children are grossly under-represented as users of mental health services. Recent annual reports of the provincial Departments of Health, Social Services and Education support this conclusion. In 1977, about 3,000 children under 16 received services from the Department of Social Services (including adoption, foster care, subsidized day care, institutional care and family support services). In 1977-78, about 3,000 children received services from the Psychiatric Services Branch of the Department of Health. In 1978-79, about 2,100 children received "high cost" special educational services such as teacher aide, resource room services, special class placements, and special schooling. An additional 11,200 children were identified as having mild handicaps and therefore received "low cost" assistance under the control of their local school divisions. The number of children who receive mental health related services from non-governmental sources only is unknown but is assumed to be relatively small. Thus, the proportion of children and adolescents receiving mental health assistance is relatively small when compared to the estimated need.

The apparent underservicing of the mental health needs of children and youth reflects the traditional lack of availability of services for this age group. During the 1950's and 1960's, deinstitutionalization of adult inpatients was emphasized in the improvement of mental health services, while children's mental health services lagged far behind in this province. Despite the improvement in availability of services generally, it is apparent that children still are not represented in proportion to their numbers or their need amongst the users of mental health services.

3. Existing Mental Health Services for Children and Youth

Mental health services are currently provided by a bewildering array of public and private agencies. Government services are provided primarily

under the aegis of the Department of Education, Health and Social Services. Voluntary agencies, which number around 20, include those focussing on advocacy as well as those emphasizing direct service to children and families. A number of services are provided by the Department of Psychiatry, University Hospital and by psychiatrists in private practice.

Depending on geographical location in the province, the availability of mental health services for children and youth varies a great deal. Services for children tend to be centralized in Regina and Saskatoon. These centres offer greater numbers of professional staff, more comprehensive specialized programmes and more adequate physical resources than their rural counterparts. Within Saskatoon alone, over 24 government branches, agencies and voluntary organizations are now involved in providing direct services to children and youth, in addition to the number of private practitioners in different helping professions. This comparative wealth of service has resulted in professionals frequently expressing difficulties in determining where to make referrals or to see appropriate consultations, since many services appear to be duplicated. As well, the individual seeking service is easily overwhelmed by the variety of agencies available to help. It is suggested that a comprehensive directory of mental health services circulated to educators and health care professionals and to the general public would ensure more appropriate utilization of existing services. Therefore, THE TASK FORCE RECOMMENDS:

33. THAT FUNDS BE PROVIDED TO ENABLE APPROPRIATE COMMUNITY-BASED AGENCIES IN EACH REGION TO COMPILE A COMPREHENSIVE DIRECTORY OF MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH.

The rual picture differs markedly from that of the urban regions. In each rural region there is a small core of professionals who provide direct service to those within reach. Due to insufficient numbers, it is not practical to provide a traveling rural service to target populations in many areas. Thus, accessibility of helping professionals is a problem for those living in isolated regions. Mental health services do not appear to

be a high priority in the voluntary sector, and few voluntary organizations and private practitioners provide services to rural children and youth. Appropriate residential treatment resources for children and youth are literally non-existent in rural areas and the consequent referrals to larger centres necessitate breaking up families and losing existing social supports within the community. Moreover, rural services to children and youth are often provided by workers whose training and major time commitments are in adult services. When a child or youth is unable to go to an urban centre, direct service is often provided by the social worker or cummunity mental health nurse who provides adult services to that particular geographical region. There may not be an opportunity for these professionals to work in close consultation with professionals in urban centres who have specific training and expertise with children. Specialized consultation services should be available to all workers in health, education and social services who provide service to rural children and youth. This consultation service is gradually becoming available in more areas through the regional mental health centres, but these specialist resources are still sadly lacking in comprehensiveness and accessibility. The need for more professional mental health resources is documented elsewhere in this report, together with recommendations for increased funding and staffing. THE TASK FORCE RECOMMENDS:

34. THAT PSYCHIATRIC SERVICES BRANCH ESTABLISH DEMONSTRATION PROJECTS, TO DETERMINE THE MOST EFFECTIVE AND EFFICIENT WAYS OF PROVIDING SPECIAL MENTAL HEALTH SERVICES TO CHILDREN IN RURAL AREAS.

4. Legislation Related to the Mental Health of Children and Youth

In certain areas, actions by the Saskatchewan legislature have a direct impact on the mental health of children and youth. The need for adoption of a children's bill or rights has already been alluded to at the beginning of this chapter.

Another legislative matter of prime importance is related to the Family Services Act. This Act, passed in 1973, provides the most significant child protection legislation in Canada. The intention of this legislation was to provide for the traditional protection of children

in cases of parental neglect, default or incapacity. However, the most forward looking parts of this legislation have not been implemented by the Government of Saskatchewan. These sections would allow parents of children with special needs to request assistance in meeting these needs at home. To date, no funds have been allocated to provide this supportive service to families. Sections 6 and 7 of the Family Services Act are even more important in the 1980's than they were when the Act was passed nine years ago. Without access to family support services, many children are left in jeopardy and in need of protection. All too often provision of protection results in removal from the family to the care of the Minister of Social Services, instead of provision of home support and treatment services. THE TASK FORCE RECOMMENDS:

35. THE IMMEDIATE IMPLEMENTATION OF FAMILY SUPPORT MEASURES PROVIDED FOR IN SECTIONS 6 AND 7 OF THE FAMILY SERVICES ACT OF 1973.

A third area in which legislation affects the mental health of children and youth in our province is in practices concerning the age of consent for health care. Current practice suggests that people under the age of 18 must have parental consent before receiving health care. However, there is no legislation which effectively speaks to this issue in Saskatchewan. The Law Reform Commission of Saskatchewan has suggested that a common law approach be taken with regard to age of consent. This suggests that the age of consent be considered to be the same age at which the potential service recipient can understand and, therefore, give informed consent. The Law Reform Commission indicates that legal precedents have already been established wherein this course has been followed. Adoption of this practice is urged since it eliminates discrimination against those young people seeking services and allows them the opportunity to practice responsibility for health care to the extent that they are capable. It is especially important for parents, youth and mental health professionals to have a clear guideline with respect to the age of consent for provision of personal counselling

services. This would eliminate current concerns on the part of professionals with respect to liability when serving youth under the age of 18. Further, this would eliminate the confusion among potential recipients of services. At present some high school students have ready access to confidential personal counselling services while other students of the same age are denied such access because of a belief that parental involvement is necessary. Clarification of this issue under the law is urgently needed.

THE TASK FORCE RECOMMENDS:

36. THAT THE RECOMMENDATIONS OF THE LAW REFORM COMMISSION OF SASKATCHEWAN REGARDING AGE OF CONSENT FOR HEALTH CARE (INCLUDING COUNSELLING) BE ADOPTED IN SASKATCHEWAN LAW.

5. Social Service for Children and Youth

The Department of Social Services is a vital mental health resource in Saskatchewan. Three areas with which the Department of Social Services is directly associated are discussed including day care, foster care resources and support services for school children during summer holidays. Each is viewed as an important area requiring upgrading in order to improve the mental health status of Saskatchewan's children and youth.

High quality nursery schools and day care settings are important both because they provide supports to families and because they can provide children with opportunities for the social and intellectual stimulation needed for optimum development. Legislation, regulations and guidelines are necessary to ensure that such settings are of high quality. It is only when services for young children are viewed from the perspective of the child that we can shift our thinking about day care from being places to babysit or store children to being essential resources which provide for the needs of the young.

A recent study on day care in Saskatchewan has identified a number of problems including: lack of adequate funding for setting up and maintaining day care

centres and hiring trained staff; high demands on parents' time; minimal regulation for required staff training; environment; and nutrition. In order to improve day care in Saskatchewan these concerns must be addressed and ameliorated. As well as providing guidelines for excellence in programmes, the provincial government must become more involved in working together with local initiatives to ensure that such programmes are in place.

Foster placements serve an essential function in providing parental care for children requiring medical treatment, educational planning or protection. Notwithstanding their important role, many foster parents are frustrated and dissatisfied with inadequate funding, lack of information, and lack of professional support. At present CORE Services, Provincial Social Services, Indian Affairs and the School Boards provide differing amounts of monthly financing. The average monthly support ranges from $430.00 for CORE to $229.00 for School Boards.* Foster parents are aware of this variance and are disturbed by it. There needs to be equitability in the funding of all children in care. Further, foster parents have identified the need for substitute foster parenting when regular foster parents must be absent from their foster children either due to illness, crisis or vacation. Foster parents have requested a change in regulations so that they would continue to receive maintenance supports for their foster children when the latter are hospitalized or on holiday. They need to be funded additionally for replacement of therapeutic aids when these are damaged or broken, for clothing for disabled foster children and for costly visits to clinics and hospitals. In order to redress these inequities and deficiencies in the present system of foster care, THE TASK FORCE RECOMMENDS:

37. THAT EQUITABLE FOSTER CARE ALLOWANCES, PROVIDING FOR SUBSTITUTE FOSTER PARENTING, AND REIMBURSEMENT OF ALL HEALTH CARE COSTS, BE PROVIDED BY ALL AGENCIES SUPPORTING FOSTER CARE PROGRAMMES.

A further gap in mental health services is the lack of support services to emotionally handicapped children during the ten week summer school vacation. During the school year they receive special educational and support services

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* at the time of writing.

from the school system. However, during the summer these services are not available and they are dependent on the resources of their families which are often inadequate for their needs. Established community programmes are not designed to accommodate these children. This is especially true in rural or isolated communities. When these children then return to school in September, social and academic regression is apparent.

The Departments of Social Services, Education and Health, in conjunction with interested voluntary and private agencies should attempt to meet the need for providing emotionally handicapped children with social stimulation, support and opportunities for skill development during the summer. This would be in the form of intensive recreation therapy programmes. Successful models already operating are the MacNeill Clinic "Ready" programme and "Camp Tamarack". These are preventative programmes which are doubly valuable as they provide respite for their families as well as benefitting the children. THE TASK FORCE RECOMMENDS:

38. THAT FUNDING BE PROVIDED TO ESTABLISH INTENSIVE RECREATIONAL PROGRAMMES FOR EMOTIONALLY HANDICAPPED CHILDREN DURING THE SUMMER MONTHS.

6. The Educational System and Mental Health

The Province of Saskatchewan provides compulsory education for its children and youth up to the age of 16. As a result, children and youth spend many years in educational environments which can facilitate or detract from their development of social skills, self-esteem, intellectual curiosity and knowledge. More and more the importance of interpersonal skills and group interaction are emphasized within the educational system. This places increasing demands on the schools, especially since it is becoming more and more common for ordinary schools to teach handicapped children side by side with normal children. In order for teachers to recognize emotional and social problems in their students and provide appropriate support or referrals, they need more consultation and inservice education in these areas than is presently available.

While the Task Force sees a need for improvements in teacher education and school consultation towards maintenance of children's mental health, it is also aware that many traditional responsibilities of the church, parents and community are now being placed on the teachers' shoulders. Even a highly motivated teacher with well-developed skills related to mental health may not be able to meet the needs of a large heterogeneous classroom containing three or four children with special needs. Thus it is shocking to note how little support is available from school-based guidance personnel. In 1978, there were only 13 guidance personnel at the elementary school level and 14 at the junior high level throughout the province. Moreover, although the Department of Education guidelines for guidance counsellors provide a clear mandate for career counselling and course selection, there is less support and encouragement for guidance counsellors to become involved in personal counselling. Many teachers who serve as guidance counsellors do not have sufficient training to be involved in personal counselling (although there are some teachers who have post-graduate diplomas or master's degrees in guidance and counselling). While the Task Force does not negate the importance to the student of course selection and career guidance, we wish to support the further development within schools of the capacity for personal counselling. The school is one of the few institutions in society which has the capacity to provide services for all children. Access to appropriate information and personal counselling should be made available through the schools. Cost-sharing arrangements between rural school boards might help make this feasible. THE TASK FORCE RECOMMENDS:

39. THAT THE DEPARTMENT OF EDUCATION BE ALLOCATED ADEQUATE FUNDING TO ENABLE IT TO MEET THE DEMANDS FOR PERSONAL COUNSELLING AND MENTAL HEALTH CONSULTATION WITH TEACHERS, DESIGNED TO PROMOTE THE MENTAL HEALTH OF STUDENTS.

In the years before 1971, there were no provincial funds available to school boards for special needs programming. At that time school boards developed special programmes for learning disabled children as they saw fit and as

their budgets permitted. Thus many learning disabled children, particularly in smaller rural school divisions, did not receive adequate special programming. Since 1971, some funding has been made available by Saskatchewan Education to help school boards meet the requirements laid out in Section 122 of the Saskatchewan School Act, although this extra funding is limited by a number of restrictions. The major method of funding has been through the designation process.

According to the regulations of the Department of Education (Special Education), there is high cost funding available to children with various physical handicaps and to three categories of psychologically handicapped children: socially-emotionally (behaviourally) handicapped, trainable mentally retarded (TMR), and severely learning disabled (LD). TMR funding is available for children with IQ scores lower than 55. LD funding is available for children with an IQ of 85 or more and with academic achievement significantly lower than aptitude. Socially-emotionally disturbed funding is available for children designated by a psychiatrist as being seriously disturbed emotionally or behaviourally. Presently, children with IQ's between 55 and 85 receive no high cost funding eventhough children with an IQ below 85 do not manage well in a regular classroom unless they receive special support services and individual programming.

The language disabled child whose Verbal IQ is below 85 will not get funding under the LD classification unless his/her Performance IQ is high enough to bring the Full Scale IQ score above 85. Many children with good intellectual potential, as reflected by an average Performance IQ score, who have very poor language abilities (reflected in a low Verbal IQ score) end up not receiving any special help. Often such children are of Indian ancestry; English is not their mother tongue, compounding their verbal difficulties. The present LD designation formula also makes it very unlikely that children in grades one and two will be designated --most LD children do not fit the formula until grades three and four-- thus early intervention is precluded.

A related problem with the present LD funding is that the instruments used to measure IQ do not always give stable results over time with children who do not progress normally through school. Children with a language disability may achieve a Verbal IQ within the average range when young, but often as they become older and they are compared with peers who are more and more sophisticated in language, their Verbal IQ scores drop. Eventually these LD children are no longer eligible for special LD funding. This problem in the present LD funding formula may explain the lack of LD children in junior and senior high school better than the explanation that LD children are "cured" in the primary grades.

The Department of Education presently requires a psychiatric examination for the designation of socially-emotionally (behaviourally) handicapped. However, there are only about six individuals in Saskatchewan at present who are qualified as child psychiatrists and they are located in Regina and Saskatoon. The volume of actual need for designation for special educational services cannot readily be met by the presently available psychiatrists without lengthy delays and extensive travelling by some candidates. Either this shortage must be rectified or certain qualified clinical child psychologists, social workers and special education consultants must be empowered to designate these children, with appropriate medical consultation where needed. Because the latter alternative is more cost effective and more suited to the highly heterogenous educational, emotional and medical needs of learning and emotionally handicapped children, THE TASK FORCE RECOMMENDS:

40. THAT LEARNING DISABLED AND EMOTIONALLY DISTURBED CHILDREN BE DESIGNATED FOR HIGH COST FUNDING BY REGIONAL PANELS CONSISTING OF MENTAL HEALTH AND EDUCATIONAL PROFESSIONALS WHO SPECIALIZE IN THESE AREAS WITH REPRESENTATION FROM THE CHILDREN'S PARENTS AND TEACHERS.

The Task Force has had its attention called to the method of funding "low cost" students as defined by the Department of Education. The

Department of Education gives an outright grant to all school jurisdictions for the development of programmes for children with handicapping conditions considered to be less serious in nature than the high cost designations. This grant is established on the basis of three percent of the student population in Divisions I, II, III (Grades 1 - 9) plus one percent of the Kindergarten population. However, this grant is not tied to any form of service delivery. Therefore, it is conceivable that some of these funds are not being used for their designated purpose. Further to this, the definition of educable mental retardation reveals that about two percent of a school division's students may be considered Educable Mentally Handicapped (EMH). Thus, it is conceivable that most of the funding available for low cost students is being channeled into programming for the EMH population, with few resources left for programming for the many emotionally disturbed children whose problems are not yet severe enough to qualify them for high cost funding. THE TASK FORCE RECOMMENDS:

41. THAT ADDITIONAL FUNDING BE ALLOCATED FOR CHILDREN WHO ARE DESIGNATED LOW COST EMOTIONALLY/BEHAVIOURALLY MALADJUSTED CHILDREN AND THAT SUCH FUNDING BE TIED TO SERVICE DELIVERY.

As families become more mobile, and as their links with grandparents and other relatives become less frequent, the opportunities for education of children in family life also diminish. It is crucial for the schools to provide instruction for young people in how to fulfill their future role as parents. The ethics and values of co-operation and membership in a community also need to be conveyed through the school years. Well-developed curricula, including concrete and specific suggestions for activities in promotion of mental health, exist and their use should be encouraged. The Task Force feels it is important to emphasize support for expanded and improved family life education in view of the recent growth in a back-to-basics viewpoint (avoiding education in the human, emotional aspects of life), which is seen as inimical to the development of ethical standards and supportive interpersonal relationships among our young people. An expanded and universally available family life

curriculum would allow schools to convey to their students realistic expectations regarding marriage and family life, and to introduce them to the skills needed for effective parenting.

7. Health Programmes

There are a number of areas in which improved health services are needed for promotion of the mental health of children and youth.

The value of pre-natal and post-natal education for parents in prevention of child abuse and neglect is now well-documented. Moreover, infant stimulation programmes have a proven effectiveness, especially in high risk or vulnerable groups, in the development of cognitive and social skills which carry on beyond infancy. Screening mothers of newborns in the immediate post-partum period has been shown to be an effective means of identifying high risk mothers and babies. Virtually all new mothers in Saskatchewan now have contact with the health care system, and programmes to teach them about the social, emotional and intellectual needs of young babies should be implemented on a trial basis in interested communities. Very young unmarried mothers would be an especially appropriate target group for this type of program.

Immediate action needs to be taken to reduce the high rate of teenage pregnancies in Saskatchewan. There is an increasing proportion of total live births being accounted for by mothers under 18 and, similarly, an increasing number of children born to unwed teenagers. It is suggested that (a) parent-taught sexuality courses be encouraged to counteract the inaccurate and misleading information obtained through friends, movies, magazines, and songs; (b) financial support be provided to groups or agencies which provide unbiased counselling regarding birth control and unwanted pregnancies; and (c) contraceptives be made more easily available. With regard to the latter, a lack of contraceptives does not prevent sexual intercourse, it only increases pregnancies. There is a trend towards earlier first intercourse. At least 45% of the 15 to 19 year olds have had intercourse, and most adolescent intercourse takes place without adequate contraceptive precautions.

The rising rate of adolescent suicide in Saskatchewan (increased 400% from 1971-1977) makes imperative the need for increasing public awareness of the suicide problem and of how stress, loneliness and depression are factors involved in suicide. There needs to be increased attention through media and schools about the importance of good parent-child and peer-peer communication, an increase in the accessibility of good adolescent counselling services (such as Saskatchewan Health psychologists or social workers making regular high school visits), and increased funding for clinical research on suicide in adolescent.

There is a serious gap in services to children and families of hospitalized psychiatric patients. Such children are at risk for developing emotional disorders, and careful supervision and support is needed. Programs for children in hospitals (particularly the preschool age group) and for children and families of children with chronic physical handicaps, should also be established through the province since these groups are also at risk for later problems. In addition to the need for services for already-identified high-risk groups, there is a need for increased broad developmental screening of children.

Early identification and diagnosis of handicaps and chronic health problems is important in effective treatment. The evidence suggests that early identification of learning and behavioural problems through screening to detect minor auditory problems, visual deficits, speech impairment, perceptual difficulties, and deficits in social behaviour, is highly desirable. Serious problems can be avoided through such early identification provided that appropriate therapeutic and rehabilitative remediation is available. The Task Force suggests that health surveillance of children in the preschool and early school years be increased: at least twice between two and six years of age, all children should be fully screened by nurses trained in pediatric and psychological assessment techniques. Children deemed to have developmental problems during this initial screening can be referred for more comprehensive and specialized assessment in a regional centre. Financial bonuses or tax incentives to parents to bring their children in for screening should be considered, as this short-term expenditure can lead to long-term

reductions of health care costs. At the present time, all four-year-olds are supposed to receive a screening visit, but this screening is often directed mainly at physical disorders (depending on the skills and interests of the nurse); moreover, when developmental difficulties are detected, there is a lack of available resources for follow-up.

Most mental health problems of children and young adolescents are referred at one time or another to the family physician. The need among general practitioners of medicine for inservice education in the recognition and treatment of emotional problems is very clear. In addition, family doctors should have access to more information about the treatment resources which are available in this province, especially those in their own communities. This should include early identification of emotional and developmental problems, effective use of available mental health services, and skill development in counselling of individuals and families in specific common areas of mental health problems. THE TASK FORCE RECOMMENDS:

42. THAT THE DEPARTMENT OF HEALTH ADDRESS THE PROBLEMS OF ADOLESCENT PREGNANCY AND ADOLESCENT SUICIDE THROUGH INCREASED FUNDS FOR PUBLIC EDUCATION, CLINICAL RESEARCH AND SPECIALIZED COUNSELLING SERVICES.

43. THAT THE DEPARTMENT OF HEALTH IDENTIFY AND PROVIDE SPECIALIZED SERVICES TO HIGH-RISK GROUPS SUCH AS HOSPITALIZED CHILDREN AND CHILDREN OF PSYCHIATRIC PATIENTS.

44. THAT THE DEPARTMENT OF HEALTH MAKE MAJOR IMPROVEMENTS IN EARLY DIAGNOSIS AND SCREENING SERVICES AT SPECIFIC DEVELOPMENTAL STAGES OF THE PRESCHOOL AND EARLY SCHOOL YEARS.

Mental health treatment services to children and families make up only a small portion of the mental health treatment services available in Saskatchewan. This proportion needs to be increased, particularly as the treatment of children has a better probability of success than

treatment of adults. Treatment services for children must be family oriented with the child's family involved as much as possible in all aspects of treatment. Such services must be multidisciplinary and multifaceted, as the treatment of children often involves the active and integrated co-operation of numerous parties, such as the health and mental health professionals, family, school, and peers.

Mental health treatment programmes should cover a broad range of services from fully outpatient counselling and consultation services to longer term residential facilities, with the focus on outpatient and short-term residential treatment programmes. Some long-term residential treatment programmes need to be available for the most severely disabled or disturbed children who cannot be properly treated within their own family or a foster care facility. Consideration should be given to a Parent Therapist Programme like the one in operation in Hamilton, Ontario. This consists of specially trained foster parents who care for severely disturbed children with the support of other parents involved in the same programme. A child may be in care for four to twelve months, and the parent-therapists help the child's own family to deal better with the child to facilitate maintenance of treatment effects.

There is also a need for expanded psychoeducational, day programmes like that of the Youth Services Programme at University Hospital in Saskatoon. These programmes serve adolescents who are unable to benefit from more traditional outpatient treatment programmes. THE TASK FORCE RECOMMENDS:

45. THAT A FULL RANGE OF OUTPATIENT AND RESIDENTIAL MENTAL HEALTH TREATMENT PROGRAMMES BE MADE AVAILABLE BY THE DEPARTMENT OF HEALTH IN EACH REGION OF THE PROVINCE.

The paucity of mental health services to children is affected by the training programmes available in this province. Adequate exposure to

child diagnostic, treatment and consultative skills is not always available to mental health trainees in this province. For example, although the clinical psychology graduate programme at the University of Saskatchewan is accredited by the American Psychological Association, indicating a generally high quality programme, there is presently no course offered in the psychological assessment or treatment of children, nor in clinical developmental psychology. Although limited practicum experience in child and youth services are available to some students, other graduates of the programme are employed in settings serving children without having had formal training in child clinical skills. Similarly, in the field of psychiatry, a thorough grounding in developmental medicine, developmental psychology, and community and family psychiatry is obtained by too few trainees.

The Task Force, therefore, urges the departments and colleges of Medicine, Education, Psychology, Nursing and Social Work to recognize their mandate to improve children's mental health services in Saskatchewan through upgraded and expanded training programmes specifically related to the needs of children. This effort will require these departments to seek and justify increased levels of public support.

3. The Voluntary Sector

Up to this point, emphasis has been on services provided by the public sector. However, as noted in earlier sections, voluntary agencies play an important role in the mental health field. The number of children who might experience adjustment problems if they did not have their involvement in Scouts, in organized sports, in Big Brothers, or in their church, cannot be estimated. As well as voluntary service agencies, there are advocacy organizations. It is interesting to note that while there are parent advocacy groups for learning disabilities and physical handicaps, there are no groups for children with emotional problems and their families.

In rural areas access to professional mental health services is difficult and expensive. When a child is transported a long distance for assessment or treatment, two unfortunate consequences occur (aside from the expense and inconvenience); the possible supportive resources available in the community may be overlooked (undermining the family's confidence in its own community), and the child is given the message that there must be something seriously wrong that merits travel to a distant centre. The concept of voluntary action in rural communities has not been fully explored in many localities, especially with regard to mental health concerns. Co-operative action has, of course, resulted in many improvements to life in rural communities, in the areas of agriculture and education for example, but common children's mental health problems such as conduct disorders are often seen as too complex to be handled locally.

The Task Force suggests that the Mental Health Association in Saskatchewan seek project funds for a demonstration rural voluntary mental health action group. This group would identify and mobilize individuals already present in the community who have skills which would be helpful in assisting troubled children and adolescents. This group would co-operatively direct parents, teachers or youths with such concerns to an appropriate voluntary resource. Such a group could be especially helpful in providing volunteers to help with various functions in the school at the request of teachers. Nonprofessionals working individually with school children are as effective or more effective than mental health professionals in handling minor adjustment problems. The demonstration voluntary action group should have clearly defined geographic boundaries and should be organized in an area where professional mental health services are sparse. However, it should be recognized that volunteer services are a component of comprehensive services and are not a reason for not funding adequate professional services for those requiring them. THE TASK FORCE RECOMMENDS:

46. THAT THE PSYCHIATRIC SERVICES BRANCH PROVIDE PROJECT FUNDS TO THE MENTAL HEALTH ASSOCIATION TO ESTABLISH A DEMONSTRATION RURAL VOLUNTARY MENTAL HEALTH ACTION GROUP.

VI(B) THE ELDERLY

The Task Force received a number of submissions regarding mental health issues affecting the elderly. In addition, a Working Group of the Task Force developed a position paper which was circulated to a number of individuals and organizations having a special interest in this area.

In addressing the question of mental health issues for the elderly, the Task Force attempted to identify:

(a) The major determinants to good mental health among the aged.

(b) The general health and social characteristics of the Saskatchewan elderly.

(c) The current utilization of mental health services by the elderly.

(d) The current and future issues facing the elderly in regard to the maintenance and improvement of their mental health.

(e) Recommendations which attempt to resolve current issues and point the way toward the resolution of future and potential issues.

The rationale for the report is based on the Working Group's mandate to examine the state of mental health services in Saskatchewan for the elderly and is also based on the Working Group's objective to provide a foundation for policy and programme initiatives in the area of mental health services for the Saskatchewan elderly.

The Task Force felt that the World Health Organization's definition of "health": "Not only the absence of disease, but a state of complete mental, physical and social well being", was especially applicable to the mental health of the elderly. The objective of maintaining and/or improving the mental health of the elderly cannot be pursued independently of ensuring the good physical health of the elderly, such as, the absence of acute illness and the stabilization of chronic disorders.

The determinants of good mental health have been succinctly identified by the Senior Citizen's Provincial Council as:

(a) Independence - to the limit of their capacity

(b) Integration - into the life of the community

(c) Involvement - in the decisions which affect their lives

The determinants of good mental health cannot be pursued without consideration to the aging process whereby not all elderly people are able to maintain the

desired level of independence, integration and involvement without some support systems provided by the family or by the community. The elderly are entitled to the full range of services which they require to maintain a maximum level of independence and, hence, to maintain the maximum level of mental health.

Where family constellations exist, such support should come from the family. Couples should be encouraged and enabled to live together. Families should be given the necessary support systems to allow them to supply the direct services to their elderly relatives. This objective will require community support services, either directly provided to the elderly or to their responsible relatives. These support services are best based in the community which can assess, more accurately, the needs of their elderly, as their needs may vary from community to community. The community is especially capable of organizing volunteers and care providers to deliver such help on a basis which is compassionate and economical.

Community based services to the elderly or to their families may be beyond the financial capacity of the local community and will require governmental assistance. The Task Force sees the role of the provincial government as providing financial assistance and ensuring that appropriate standards are set and maintained. The two principles which need to be underlined concerning the provision and maintenance of mental health services are:

(a) Community involvement in the planning and provision of services.
(b) The use of indigenous community resources (e.g. volunteers) to provide those services.

It is not recommended that the provincial government provide direct services to the elderly or to their families except in the cases of income maintenance, unless the community lacks the capacity to provide these services. Implicit in this approach is the belief that every effort should be made to support the elderly in their own community without dislocation and the loss of involvement which may be the consequence of geographical or community change

at this time of life.

Approximately 9% of the elderly in Saskatchewan become sufficiently impaired physically or mentally to be incapable of complete independence or community living. For these elderly, a full range of living and treatment facilities are required. However, the basic principles of independence, integration and involvement must be maintained to the greatest possible degree.

CHARACTERISTICS OF THE ELDERLY POPULATION IN SASKATCHEWAN

Overview:

A review of the characteristics of the Saskatchewan population reveals:

(a) The elderly are representing an increasing portion of the total provincial population. (Increases in relative numbers of elderly persons are being more than offset by decreases in relative numbers of children with the consequence that the proportion of dependent persons to independent persons in the population is not changing very much -- Ridler 1979.)

(b) The ratio of females to males is increasing, particularly in the oldest segments of the population.

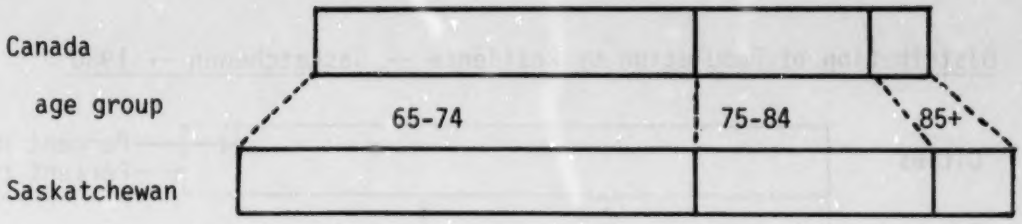
(c) There are increasing numbers of widows and widowers.

(d) Elderly persons are over-represented in the populations of towns and villages and under-represented in both cities and on reserves.

(e) Elderly persons in Saskatchewan are more likely to be cared for in institutions other than psychiatric facilities than other elderly persons in most other provinces.

Number of Elderly Persons in Saskatchewan - In 1980 there were approximately 114,000 persons 65 years of age and older living in this province. They constitute 11.6% of the Saskatchewan population -- a larger proportion than that found in any other province. The portion of the population over 65 years of age has increased from about 11.1% in 1976 to the current level. Relative numbers are expected to continue to increase slowly during the next 30 years (to over 12% by 2000) and much more rapidly after that. The numbers of "old-old" persons (aged 85+) will show the most dramatic increase.

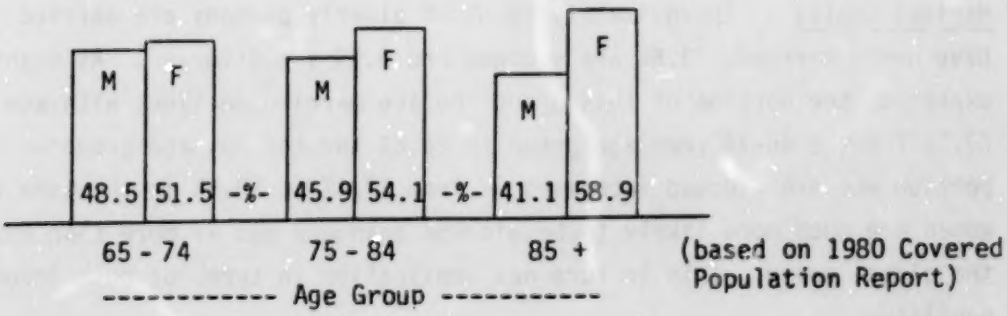
The Elderly as a Percent of the Total Population



(based on the 1976 Canadian Census)

Sex Ratios - There is a slight excess of males over females in the province's population. This excess reverses in the elderly population and the disparity becomes more extreme with advancing age. Life expenctancies in Saskatchewan exceed those in all other provinces and Saskatchewan women have life expectancies at birth that exceed male life expectations by 7.5 years (78.8 vs. 71.1 years).

Sex Ratios by Age Group -- Saskatchewan -- 1980

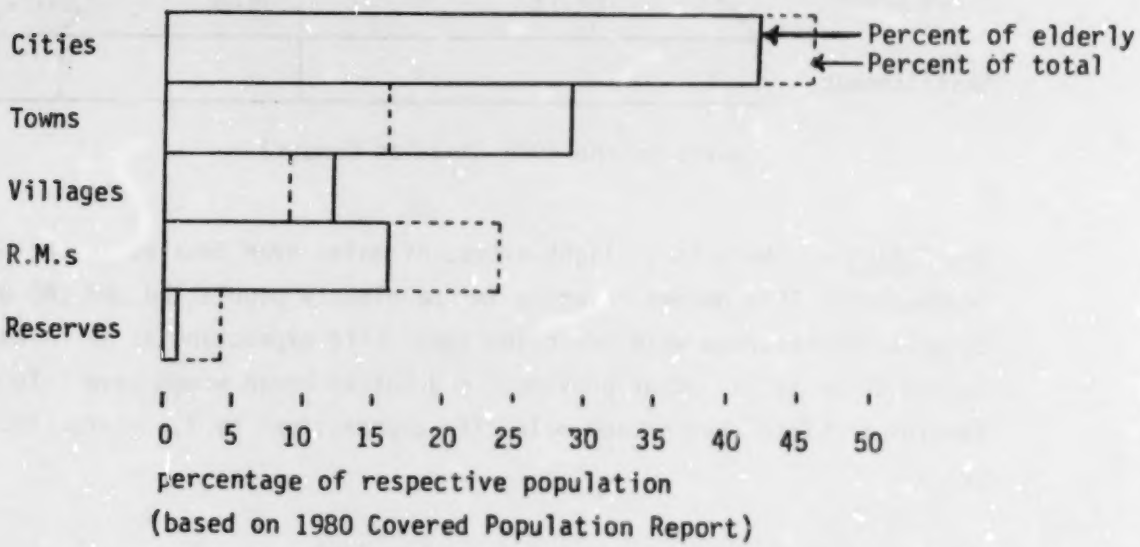


(based on 1980 Covered Population Report)

Distribution of Population - In relative terms the elderly are under-represented in cities, rural municipalities and on Indian Reserves and are over-represented in towns and villages (this is a generalization, particular to cities, towns,etc., may not reflect this pattern). Because services tend to be concentrated in the cities and because many of the elderly --particularly

elderly women -- experience reductions in mobility, we may expect particular problems in delivering services to the elderly.

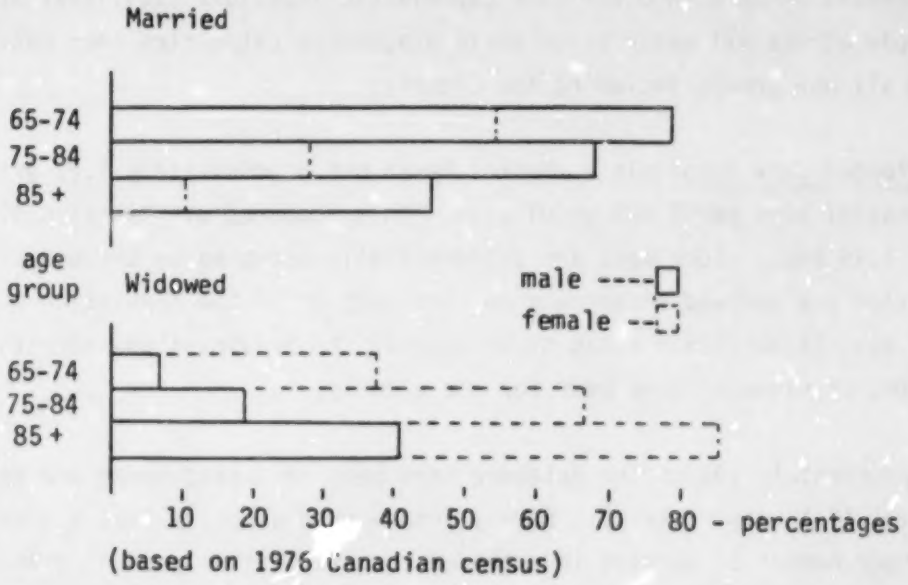
Distribution of Population by Residence -- Saskatchewan -- 1980



(based on 1980 Covered Population Report)

Marital Status - Approximately 56.8% of elderly persons are married, 8.8% have never married, 33.5% are widowed and 0.9% are divorced. As might be expected, the portion of this group who are married declines with age -- from 67.1% for the 65-74 year age group to 26.6% for the 85+ age group -- and the portion who are widowed increases -- from 22.4% to 65.5% in the same age groups. Women are much more likely to be widowed than are men -- more than 85% are in the oldest group. This in turn has implication in terms of both income and mobility.

The Elderly Population by Marital Status and Age Group



(based on 1976 Canadian census)

Income - Poverty is a problem faced by many of the elderly. Although reliable information relating to actual wealth was not available, it is known that more than one-half of all persons over the age of 64 years qualified for the Guaranteed Income Supplement (that is, having incomes below $5,289 for a single person; and $10,578 for a married couple). Unattached persons are more likely to qualify than are married -- 70% vs. 40%. Approximately 32% of Saskatchewan's seniors have incomes below the recognized "poverty level".

UTILIZATION OF MENTAL HEALTH SERVICES BY THE ELDERLY IN SASKATCHEWAN:

Psychiatric Services Branch - Peak utilization rates for both inpatient and outpatient services are found in late middle age and service rates for the elderly population tend to be on the high side of the general population average. The pattern of diagnosis shifts away from the neuroses and character disorders toward the psychoses and dementia. Irrespective of diagnoses, elderly inpatients tend to be hospitalized for substantially longer periods of time than are younger patients (an average of more than 100 days per inpatient vs. fewer than 60 days).

Saskatchewan was the Canadian pioneer in large scale community psychiatry and currently has the lowest institutionalization rate in the country. This emphasis on care in other than psychiatric inpatient facilities appears to apply across all major psychiatric diagnostic categories (not retardation) and to all age groups including the elderly.

Extended Care Hospitals - Saskatchewan has approximately 1.22 extended care hospital beds per 1,000 population. This compares with a national average of 1.19 beds. Such beds are differentially occupied by the elderly. When ratios are derived based only on that portion of the population over 64 years of age, Saskatchewan ranks sixth amongst the provinces and territories in terms of extended care beds for the elderly.

Approximately 19% of the extended care beds in Saskatchewan are designated Level IV-A (psychiatric). Survey information suggests that a significantly larger number of persons in extended care facilities present significant psychiatric symptomatology but for administrative reasons are not designated as Level IV-A; therefore, the 19% in all likelihood underestimates the actual number of persons in these facilities with significant psychiatric symptomatology.

General Hospitals - The elderly account for approximately 42% of all hospital days in Canadian general hospitals. Psychiatric conditions represent about 3% of the elderly patients' hospital days in Canada, while representing approximately 4% of the elderly patients' hospital days in Saskatchewan. The average length of stay for psychiatric conditions for the period April 1978 to March 1979 was 12.3 days; while the average length of stay in the same period for all diagnoses was 8 days. Average lengths of stay tend to be longer with psychiatric diagnoses than with most other medical conditions. This observation may well be confounded by under diagnoses and by a lack of alternative treatment facilities.

Nursing Homes - Saskatchewan ranks fourth amongst provinces in numbers of nursing home places per 1,000 elderly (48.2% vs. a national average of 33.55).

Approximately 7,200 persons -- or 6.3% -- of persons over age 64 are currently in nursing homes. Adding the approximately 1,000 elderly persons in the extended care facilities, the percentage increases to 7.2%.

Even overlooking the possibility of under-reporting discussed above, the likelihood that we have transferred rather than eliminated institutionalization suggests itself.

PROBLEMS AND ISSUES:

The Working Group on the Elderly identified the following problems and issues facing the elderly:

(a) the maintenance of financial independence;
(b) the utilization of public services;
(c) living accommodations;
(d) the potential for increasing dependence on family and community; and
(e) discrimination.

(a) Financial Independence:

The desired goals for a mentally healthy old age are aided by wise, pre-retirement planning for financial independence and a maintenance of interest and activities. Pension schemes, both private and governmental, should be designed to provide the financial independence that is necessary if the elderly are to be able to live without poverty-related anxiety or the inability to access services already provided within society. Concomitant with the need for financial independence is the need for the elderly to be able to maintain an active working life, if it is so desired, beyond the age prescribed by law. The enforcement of compulsory retirement legislation and policies within government and private organization inflict an enormous burden upon those elderly people who wish to continue an active working career. As indicated by the large number of elderly people who receive government assistance programmes, the financial health and, therefore, the mental health of the elderly is placed in serious jeopardy by inadequate financial support programmes.

THE TASK FORCE RECOMMENDS:

47. THAT SENIOR CITIZENS' INCOME LEVELS BE RAISED TO AN ADEQUATE LEVEL EITHER THROUGH ADJUSTMENTS OF THE CANADA PENSION PLAN OR THE IMPLEMENTATION OF A GUARANTEED ANNUAL INCOME.

48. THAT MANDATORY RETIREMENT POLICIES BE REVIEWED AND REVISED TO ENABLE THOSE ELDERLY SO DESIROUS, TO MAINTAIN AS VIGOROUS A WORKING CAREER AS THEY ARE CAPABLE.

(b) Utilization of Public Services:

In order for the elderly to appropriately utilize public services, the services must first be available. The service must then be accessible and useable within the financial and physical constraints placed upon the aging population. In terms of accessibility, services must not only be geographically accessible, but must also be financially accessible. While some public services may meet these two basic criteria, there will still be a portion of the elderly population which will require active stimulation by a third party in order for them to access these public services. Whether this will be forthcoming may be dependent on the awareness of third parties (family, friends, neighbours, etc.) of the existence of community services. The Task Force was informed that this frequently was not the case. In order to counteract this, THE TASK FORCE RECOMMENDS:

49. THE ESTABLISHMENT WITHIN EACH MENTAL HEALTH REGION OF A REGIONAL CO-ORDINATOR FOR SERVICES TO THE ELDERLY. THE FUNCTIONS OF THE CO-ORDINATOR WOULD INCLUDE (A) THE IDENTIFICATION OF COMMUNITY RESOURCES; (B) LIAISING WITH HUMAN RESOURCE AGENCIES WHOSE ACTIVITIES INVOLVE THE ELDERLY; (C) PUBLIC DISSEMINATION OF INFORMATION RELATING TO AVAILABLE COMMUNITY SERVICES; AND (D) THE IDENTIFICATION OF GAPS IN COMMUNITY PROGRAMMES.

Community programmes must incorporate the elderly and not segregate them. In order to ensure this, THE TASK FORCE RECOMMENDS:

50. GOVERNMENT FUNDING OF COMMUNITY PROGRAMMES SHOULD BE ON THE BASIS THAT THESE PROGRAMMES ARE ACCESSIBLE TO THE ELDERLY.

(c) Living Accommodations:

The development and maintenance of appropriate living accommodations for the elderly must take into account the special requirements of this population. It is important that the elderly be allowed to remain in their own residence as long as they desire and as long as it is physically possible. The ability to maintain a family residence may be complicated by physical impairment or financial destitution. On the other hand, the failure to provide this opportunity could result in increasing demands for public housing, adding to the tax burden of the community. Therefore, programmes that assist in the maintenance of the elderly in their own home will not only benefit them but society as a whole. Public housing developments should be located near shopping plazas or in areas where there is considerable, visible activity and where there is potential for all age groups to meet and mingle. The location of public housing requires careful consideration in order to prevent the development of "elderly ghettos" in our cities, towns or municipalities.

(d) Increasing Dependence on Family and on Community:

The elderly have an increasing potential to become dependent on the family and/or their community for many of the things that they could once do for themselves. This burden could have a significant impact on family life or indeed the community. In order to encourage families to maintain their elderly at home, various incentives should be available to help reduce the burden. Such incentives could include a range of services including financial support, day care facilities, week-end home makers, respite beds, sitters, etc. Such measures would enable the elderly to remain in an active and growing social environment without causing undue hardship to their family.

In order to forestall the premature institutionalization of the elderly, THE TASK FORCE RECOMMENDS:

51. THE PROVISION OF FINANCIAL SUPPORT TO EXTENDED FAMILIES FOR SIGNIFICANT ALTERATIONS TO THE FAMILY RESIDENCE REQUIRED TO ACCOMMODATE THE ELDERLY WITHIN THIS HOME.

52. THE PROVISION IN EACH REGION OF A FULL RANGE OF RESPITE SERVICES FOR THE ELDERLY, INCLUDING SHELTERED DAY CARE, EVENING CARE OR RESPITE BEDS.

(e) Ageism:

The elderly are often discriminated against solely because of their age. They do not enjoy the same protection in law that most other members of society do with respect to housing, employment, etc. This is best exemplified in Saskatchewan by the exclusion of the elderly from the recent Human Rights legislation.

There is the need for a broad educational approach to improve existing societal attitude to aging and the elderly. While this requires an attack along a broad front, ranging from school curricula to professional training, there is still a need for a public awareness programme along the lines of the "Feeling Good" campaign. THE TASK FORCE RECOMMENDS:

53. THAT THE PROVINCIAL AND FEDERAL GOVERNMENT RECOGNIZE THE NEED TO CORRECT THE NEGATIVE SOCIETAL ATTITUDES TOWARDS AGING AND THE ELDERLY BY MEANS OF A FEDERALLY AND PROVINCIALLY SPONSORED MEDIA CAMPAIGN.

Saskatchewan is in need of palliative care programmes for the terminally ill. The hospice movement which has gained increasing support in other parts of the continent and particularly in the United Kingdom, has been slow to take hold here. The need for the value of hospices is, however, well documented. It is established that they provide a secure, dignified, pain-free environment for the terminally ill and are far more appropriate than the hspital setting because of their emphasis on care rather than cure. The Task Force is convinced that there is an immediate need for such a programme on a province-wide scale. ACCORDINGLY, IT RECOMMENDS:

54. THAT THE MINISTER OF HEALTH ESTABLISH A HOSPICE CARE COMMITTEE TO FACILITATE THE INTRODUCTION OF HOSPICES ON A PROVINCE WIDE BASIS.

PROFESSIONAL TRAINING PROGRAMMES:

Population statistics indicate that a growing proportion of our population will consist of people over 65. This carries with it the prospect for increased demands for all services including Health and Mental Health services. A number of briefs from individuals, nursing home operators, psychiatrists and nurses indicated the need to establish adequate training programmes in various Health and Social Service disciplines in order to meet the future challenge. The absence of appropriately trained professionals is one of the major obstacles to the development of mental health services to the elderly. In order to rectify this, IT RECOMMENDS:

55. THE ESTABLISHMENT OF BURSARIES FOR THOSE PROFESSIONALS AND NON-PROFESSIONALS CURRENTLY WORKING WITH THE ELDERLY TO ENABLE THEM TO UPGRADE THEIR KNOWLEDGE AND SKILLS.

56. PROVISION OF ADDITIONAL FUNDS TO THE UNIVERSITIES AND THE VOCATIONAL COLLEGES TO ENABLE THE ESTABLISHMENT OF APPROPRIATE TRAINING PROGRAMMES IN HEALTH CARE FOR THE ELDERLY.

57. THE DEVELOPMENT, ON A REGIONAL BASIS, OF FORMAL INSERVICE TRAINING PROGRAMMES FOR THOSE WHO WORK IN NURSING HOMES, EXTENDED CARE HOMES AND GENERAL HOSPITALS.

It is the Task Force's expectation that by focusing more attention in our professional training programmes on the normal aging process as well as diseases in the elderly, our ability to provide early and appropriate intervention may forestall the need for institutionalization for many of our elderly.

VI(C) INDIAN ANCESTRY

The Task Force, in reviewing the area of mental health services to Saskatchewan citizens of Indian ancestry, identified: (a) some of the social, cultural, economic and political factors contributing to mental health problems among the Indian and Native peoples; (b) the current utilization of mental health services by Indian and Native peoples, and (c) factors involved in the possible improvement in the organization and delivery of mental health services to these groups.

During the last three decades Indian and Native peoples in Saskatchewan have experienced increasing economic, psychological and cultural pressures which have shaped their relationship to the non-Indian society.

In the 1950's the Indians were, for the most part, living on relatively isolated reserves. Their economies were based largely on federal welfare payments but they were supplemented by seasonal hunting, fishing and labouring. The Federal Department of Indian Affairs was dominant in economic, political, educational and even cultural matters. Its objective and the objective of federal government was to assimilate Indians into mainstream cultural values. Indian children, for example, learned English rather than their own languages. Traditional Indian religious practices and values were also largely suppressed. Since the Department of Indian Affairs' representative had the authority to administer federal funding in the form of welfare payments, housing and medical services, the political power of Band Councils was largely undermined. The result was a diminution of knowledge about Indian culture and heritage and a massive decrement in self respect. Resentment, anger and frustration festered and for many, life became bearable only with the help of alcohol.

With the implementation of a provincial grid road system, the isolation of the Reserves became less severe, particularly during the 1960's. The introduction of television in this same period heralded the introduction of American cultural values. The disrespect for tradition and the challenge to established authority that characterized the 1960's in North America made

their impressions. Forces were developing which would demand political and cultural change. These forces became visible in the 1970's.

New demands for services, opportunities and changes which could not be met with existing resources characterized the 1970's. As a result, some political and educational changes were realized but economic changes proceeded at a snail's pace. The 1960's marked a shift of some political power from the Department of Indian Affairs back to the elected Band Councils. Band Councils were increasingly consulted and they became responsible for administration of more and more day-to-day matters. Band Councils established Reserve schools, many of which were staffed by Indian teachers.

In the economic area, few improvements have occurred. Although more Indians are employed by Band Councils in providing local services - constructing roads and improving Reserve housing stock - the increase in Reserve populations owing to a "baby boom" in the 1960's far outstripped the increase in Reserve employment opportunities. Thus, Indian people on Reserves are still predominantly unemployed and living in poverty. Many have migrated to urban centres in search of educational and employment opportunities. These changes lead to stress, most noticeably among Saskatchewan's Treaty Indian population but similar forces were also exerting pressures on the province's non-status Indians and Metis. Family pressures resulting from inadequate housing, crowding and poverty characterize many Indian and Native families. The cultural revival has accentuated loss and separation for those who have chosen to move away from the Reserves and yet for those who remain on Reserves, conditions are deplorable. This no-win situation produces intense reactions of anger, anxiety, depression and hostility. Friction results from difficulties in reconciling new values with the more traditional Indian and Native values.

Lacking adequate education, work experience and specific employment skills, many Indians and Natives have great difficulty in obtaining steady employment. Rates of welfare dependency are, consequently, disproportionately high. Rejection and condemnation lead to frustration and depression. Some seek

companionship in drinking establishments and a disproportionate number of Indians are picked up by the police because of violent alcohol-related behaviour, or brought to the emergency wards of general hospitals because of emotional breakdown.

During the 1980's it is anticipated that Indian and Native people will continue to migrate to Saskatchewan cities where they will undoubtedly experience problems adjusting to urban environments. It is anticipated that they will continue to experience high levels of emotional distress and alcohol abuse and will continue to make increasing use of psychiatric treatment services. Services must be available to deal with these problems and with their underlying causes. Creative planning must be instituted to decrease the number of social casualties among this group in society.

1. FACTORS CONTRIBUTING TO MENTAL HEALTH PROBLEMS AMONG INDIAN AND NATIVE PEOPLE IN SASKATCHEWAN TODAY.

Sol Sanderson, Chief of the Federation of Saskatchewan Indians, in an address to the Saskatchewan Branch of the Canadian Mental Health Association, stated:

> *Our economies have been disrupted by the twin-pronged penetration of developers and bureaucrats. The industrial frontier has spread to Indian home lands. Our local and regional political systems have been subverted by alien systems designed to make our leaders into low ranking program managers. Our elders and medicine men have had their wisdom and their skills discredited by aggressive professional associations from the settler society. Our way of life has been disorganized by the introduction of a cash economy, the introduction of inappropriate technology, the imposition of an alien education system, the pervasive influence of a bureaucracy which touches every aspect of our lives.*
>
> *Bureaucrats tell us where to live, they even impose their designs for our houses. They regulate our income, our education, welfare, economics, political organizations and even our cultural programs.*

It is clear that the white settler society has had an effect upon every aspect of established Indian and Native society. Their lands have been

invaded, their respected citizens denigrated, their traditional values mutilated, and their education overwhelmed by ill-fitting alternatives. The end result has been that their culture has been suffocated. This is the current status of Indian and Native society in Saskatchewan. All of the aforementioned factors individually, collectively and on interaction with one another, have had an enormous effect upon the mental health of our first citizens. Every effort must be made to permit the Indian members of our society to restore themselves to productive independence and to regain the self-respect to which they are entitled.

The economic, social and health conditions of persons of Indian ancestry, whether they reside on or off the Reserves, are deplorable. Life expectancy is ten years less than the average for the general population. Violent deaths occur at three times the normal rate; suicides are six times higher. Incarceration rates are grossly out of proportion and as many as half of all children removed from their homes and taken into care by the Department of Social Services come from this segment of the provincial populace.

People of Indian ancestry are poorly equipped to compete in the job market. Fewer than 3.5 percent have completed high school. An estimated 70 percent have not completed Grade Nine. In addition, when they try to get a job they are likely to encounter racial prejudice, ignorance or indifference from the white society. Their living conditions are characterized by serious overcrowding, poor sanitary facilities and hazardous heating arrangements. Both in urban and rural settings there are high levels of alcohol abuse and welfare dependency.

2. SERVICE UTILIZATION:

An examination of hospitalizations amongst the Treaty Indian population reflects general health standards. The volume of hospital care amongst Indian children is 3.5 times greater than that for non-Indian children. For Indican children under the age of one year, the rate of hospitaliza-

tion is 5 times that of the general population. Treatment for infective and parasitic diseases amongst Indian children is 3 times as frequent as that for non-Indian children.

Only two studies have attempted to compare the prevalence of psychiatric disorder among Saskatchewan Indian and non-Indian populations. summarizes their findings. In 1970, Roy et al, surveyed the prevalence of psychiatric disorders on 10 Indian Reservations and in 18 rural municipalities in the North Battleford area. The overall rate of psychiatric disorder was found to be 273/10,000 population - 80 percent higher than the rate of 152/10,000 among the non-Indian population. The Indian population had a higher prevalence rate than the non-Indian population for every major category of psychiatric disorder. Another Saskatchewan Study, by Martins in 1972, compared the level of anxiety among a randomly selected sample of Indian people on 8 Reservations and non-Indian people in 17 rural municipalities. Sixty-five percent of the Indian sample indicated that they had one or more anxiety symptoms compared to only 50 percent of the non-Indian population.

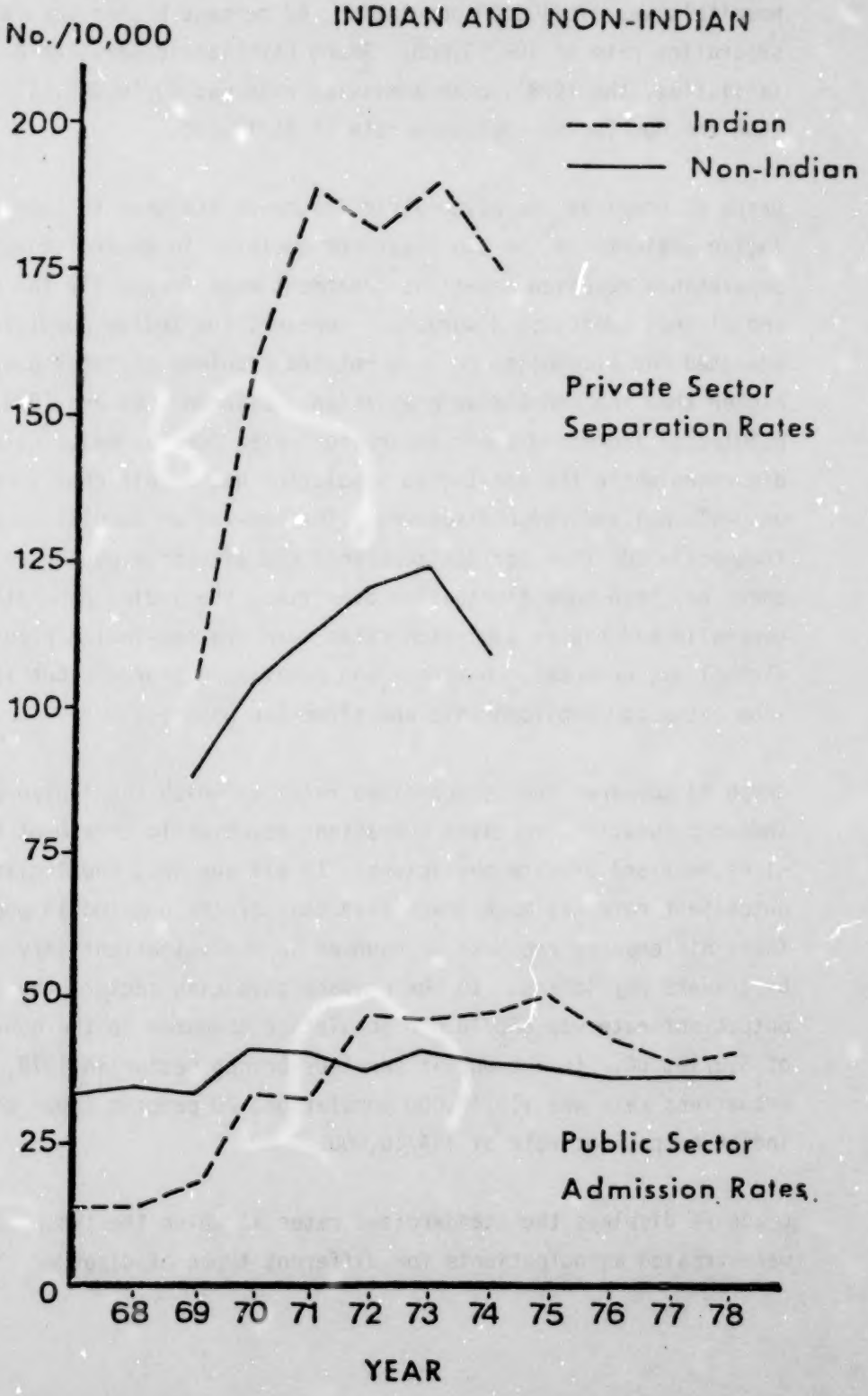
These findings might suggest the Indian population has higher rates of treatment than the non-Indian population for all major categories of psychiatric disorder. However, analyses of data comparing Indian and non-Indian use of services in the different psychiatric treatment sectors show that this is not the case. Moreover, Indian status is found to strongly influence the type of psychiatric problem treated and the type of services provided by the different psychiatric service sectors.

Graph #1 displays the standardized psychiatric admission/separation rates for the Saskatchewan Indian and non-Indian populations in general hospitals and Psychiatric Services Branch designated facilities. In both sectors since 1972, the Indian population has been more frequently admitted for psychiatric care than the non-Indian population. Psychiatric admission rates have also been increasing faster among the Indian than the non-

GRAPH 1

NUMBER OF PSYCHIATRIC ADMISSIONS/SEPARAT
PER 10,000 POPULATION

INDIAN AND NON-INDIAN



Indian population. In 1974, the Indian separation rate in general hospitals was 176/10,000 population, 62 percent higher than the non-Indian separation rate of 109/10,000. Among Psychiatric Services Branch inpatient facilities, the 1978 Indian admission rate was 40/10,000, 11 percent higher than the non-Indian admission rate of 36/10,000.

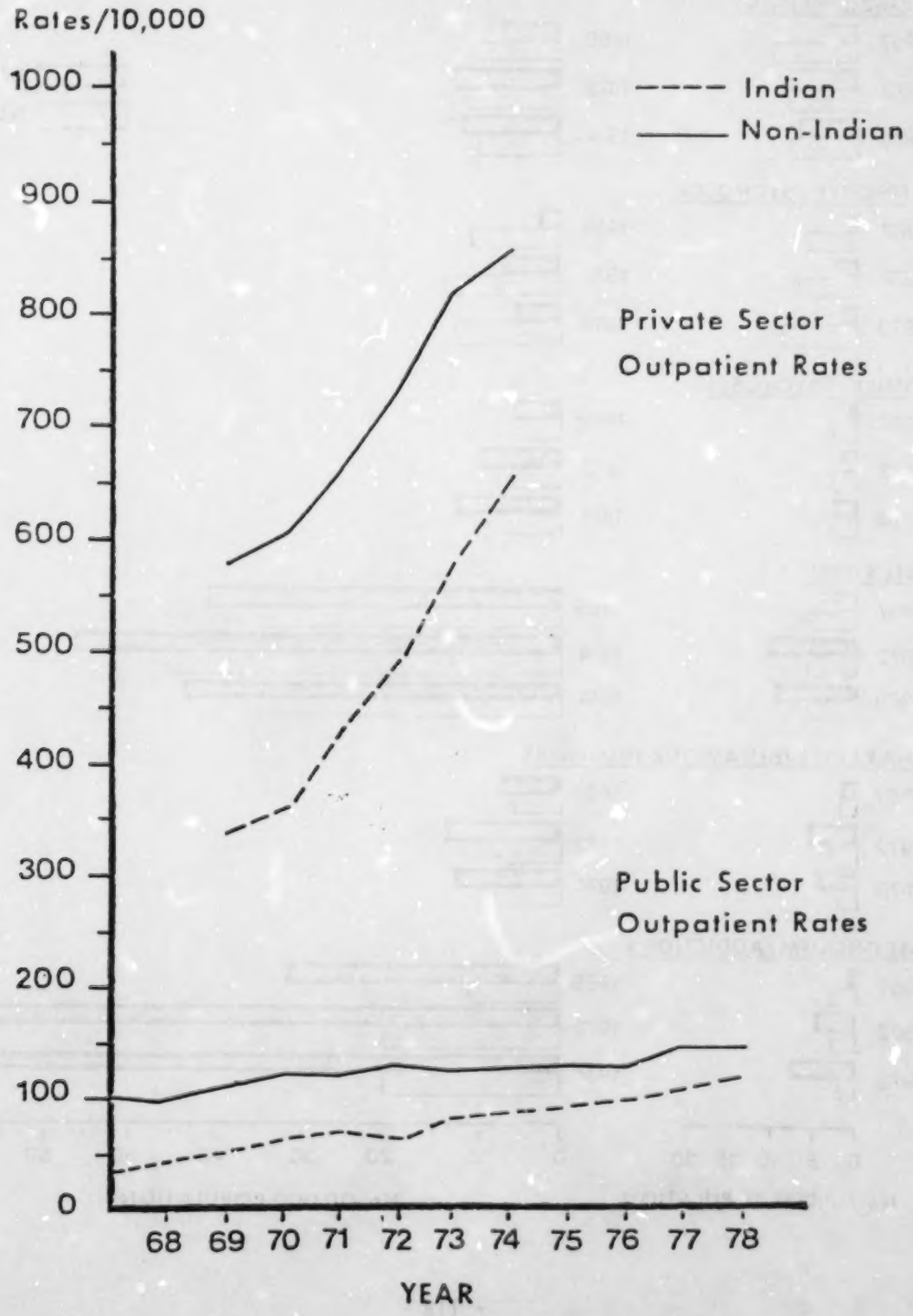
Graph #2 compares the psychiatric diagnosis assigned to Indian and non-Indian patients in the two treatment sectors. In general hospitals both populations received inpatient treatment most frequently for neurotic and alcohol addiction disorders. However, the Indian population was admitted for alcoholism or drug related problems at rates over 3 times higher than the non-Indian population. Between 1909 and 1974, the Indian population increased their separation rates for all major categories of disorders while the non-Indian population had significant increases for only alcohol addiction disorders. The non-Indian population was more frequently admitted for schizophrenic and affective psychoses. Although there has been some fluctuation over time, the Indian population has generally had higher admission rates than the non-Indian population for alcoholism, neuroses, character and behaviour disorders but lower admission rates for schizophrenic and affective psychoses.

Graph #3 compares the standardized rates at which the Indian and non-Indian populations received outpatient psychiatric treatment from Branch clinicians and private physicians. In all sectors, the Indian population's outpatient rate was much lower than that of the non-Indian population. These differences are most pronounced in the outpatient services provided by private physicians. In the private physician sector, the 1974 Indian outpatient rate was 660/10,000 population compared to the non-Indian rate of 855/10,000. In the public services branch sector in 1978, the Indian outpatient rate was 115/10,000 population, 20 percent lower than the non-Indian outpatient rate of 144/10,000.

Graph #4 displays the standardized rates at which the two populations were treated as outpatients for different types of disorders by private

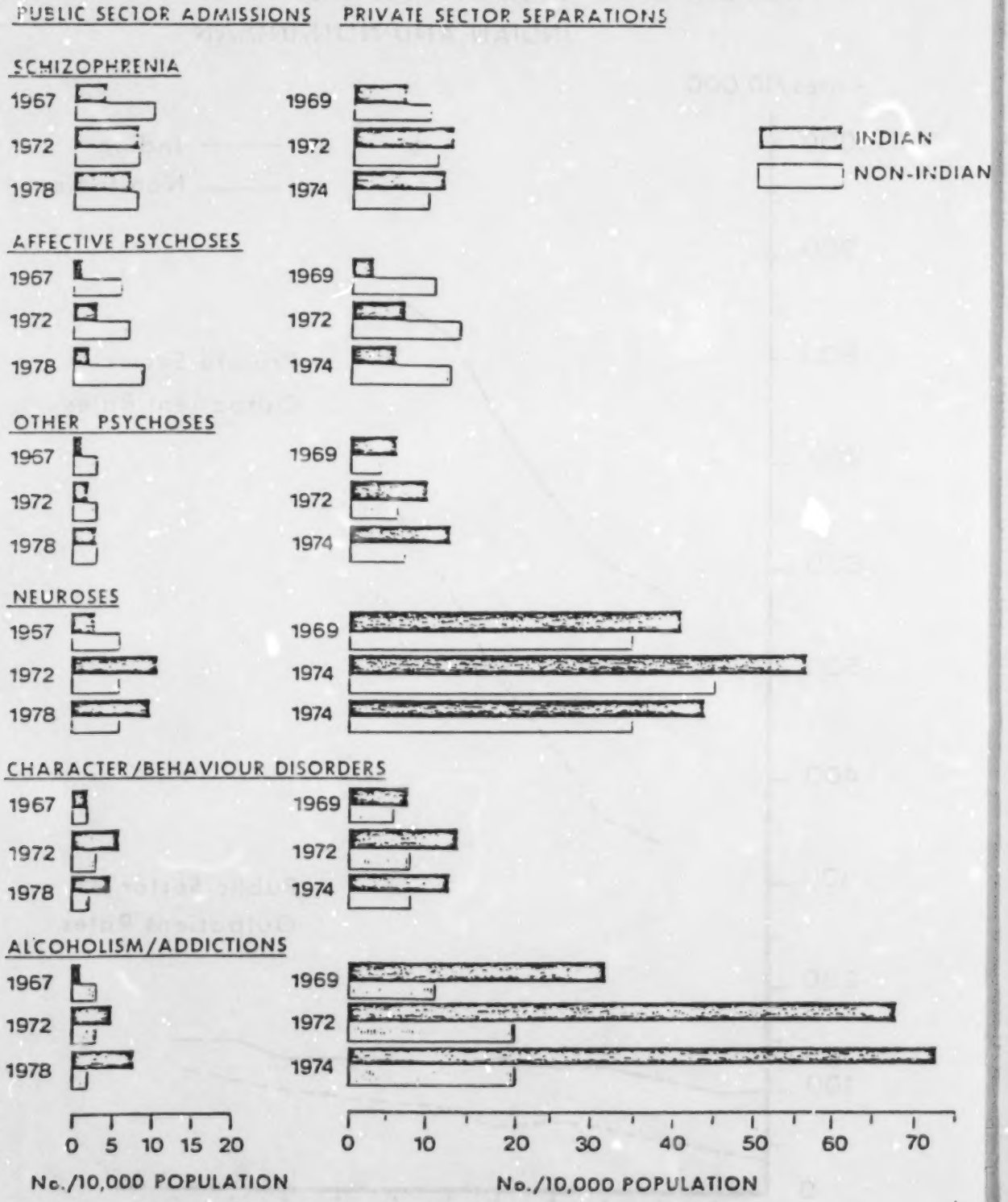
GRAPH 2

NUMBER OF PSYCHIATRIC OUTPATIENTS PER 10,000 POPUL
INDIAN AND NON-INDIAN



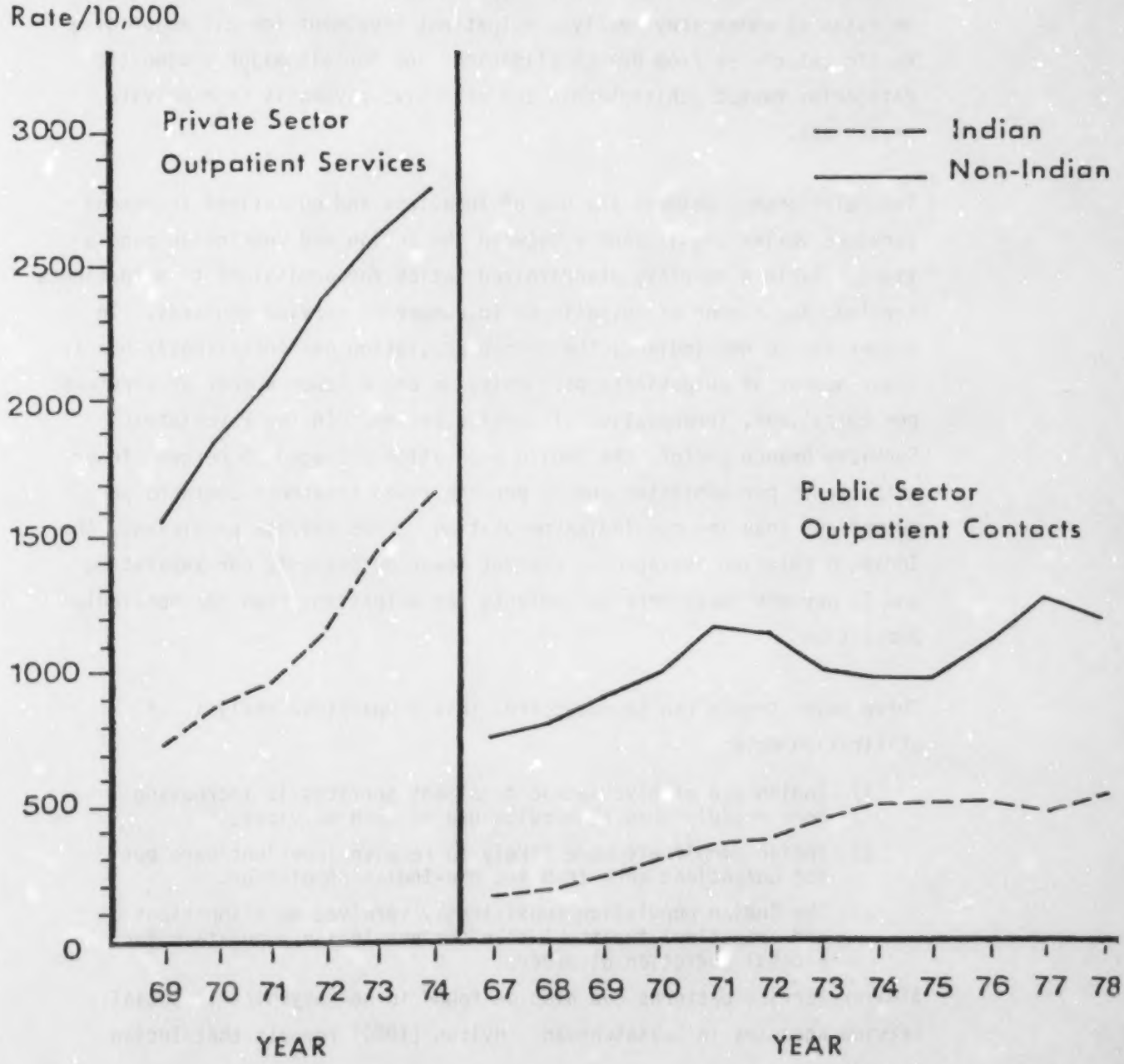
GRAPH 3 .

NUMBER OF PSYCHIATRIC ADMISSIONS/SEPARATIONS PER 10 000 POPULATION, COMPARED BY MAJOR DIAGNOSTIC CATEGORY, TREATMENT SECTOR AND INDIAN STATUS



Graph 4

NUMBER OF PSYCHIATRIC OUTPATIENT SERVICES/CONTACTS
PER 10,000 POPULATION
INDIAN AND NON-INDIAN



physicians and Branch clinicians. In both sectors, both populations were most frequently treated for neurotic disorders. However, in both sectors the Indian population received outpatient care less frequently than the non-Indian population for every major diagnostic category except alcohol addiction disorders. The Indian population showed consistent increases in rates at which they received outpatient treatment for all major diagnostic categories from Branch clinicians and for all major diagnostic categories except schizophrenia and affective psychosis from private physicians.

The relationship between the use of inpatient and outpatient treatment services varies significantly between the Indian and non-Indian populations. Table 4 displays standardized ratios for admissions to outpatients treated, and number of outpatients to number of service contacts. In comparison to non-Indians, the Indian population has consistently had a lower number of outpatients per admission and a lower number of services per outpatient, irrespective of service sector. In the Psychiatric Services Branch sector, the Indian population averaged 35 percent fewer outpatients per admission and 30 percent fewer treatment contacts per outpatient than the non-Indian population. From private physicians, the Indian population averaged 54 percent fewer outpatients per separation and 23 percent fewer service contacts per outpatient than the non-Indian population.

Three major trends can be noted from this comparative analysis of utilization data:

1) Indian use of psychiatric treatment services is increasing more rapidly than non-Indian use of such services.
2) Indian people are more likely to receive inpatient care but not outpatient care than the non-Indian population.
3) The Indian population consistently receives more inpatient and outpatient treatment than the non-Indian population for alcohol addiction disorders.

Similar service patterns can also be found in non-psychiatric social service agencies in Saskatchewan. Hylton (1980) reports that Indian

people are grossly over-incarcerated in Saskatchewan Correctional Centres when compared to the non-Indian population; that Indian incarceration rates are increasing faster than non-Indian incarceration rates and that Indian people are particularly likely to be incarcerated for alcohol related offences. The Saskatchewan Department of Social Services is also found to use an inpatient/incarceration approach far more with Indian children than with non-Indian children. Hepworth (1980) notes that although Indian people constitute less than 5 percent of the provincial population, Indian children account for 25 percent of the total number of children removed from their homes and taken into custody by the Department.

3. ORGANIZATION AND DELIVERY OF MENTAL HEALTH SERVICES:

Many social, economic, health and other services that are available to the non-Indian population of the province are either not available to the Indian ancestry population or they are available only on a selective basis. Part of the reason for this is the complex split of government jurisdictions that more often than not means the client suffers. In addition, however, the current service delivery system, even where a clear mandate exists, often does not respond adequately to the needs of persons of Indian ancestry.

Social, economic, health and other services tend to be concentrated in urban areas, yet most persons of Indian ancestry reside in rural areas or on Reserves. Even where the urban centres have a mandate to serve large geographic catchment areas, they are seldom effective in covering Reserves and rural areas. This is particularly true of many more isolated areas in Northern Saskatchewan.

Even where professionals go out to rural areas, the "drop-in" mentality is seldom conducive to adequate service delivery. Often professionals have little understanding of Native culture or history, and language barriers may also pose a problem. When persons of Indian ancestry must travel to a distant urban centre to receive physical/mental health or other social services, disruptions are even more acute. The number of

Indian ancestry staff typically does not permit the service delivery system to become sensitized to the needs or problems of persons of Indian ancestry who are seeking help.

But there are more fundamental problems with the present service delivery system. Many programmes and services are centralized and insensitive to input from local communities. The services offered are frequently based on paternalistic assumptions that place the Indian ancestry population in the role of passive recipient. Persons of Indian ancestry have little or no say about what services are offered, by whom, or where such services could most appropriately be located. Moreover, the services that are available frequently undermine Native culture and history by explicitly or implicitly providing incentives for the Indian ancestry population to abandon their heritage and assimilate into the larger non-Indian society. In fact, assimilation is often a pre-requisite for receiving adequate services. These policies ensure that services will not respond adequately to local needs and they prevent the Indian ancestry population from exercising the control over their own lives that they rightly deserve.

THE TASK FORCE THEREFORE RECOMMENDS:

58. THAT THE MAXIMUM FEASIBLE CONTROL OF ALL HEALTH, EDUCATION AND SOCIAL SERVICES PROVIDED TO PERSONS OF INDIAN ANCESTRY (STATUS AND NON-STATUS INDIANS) BE GIVEN TO THEM BY INVOLVING THEM IN BOTH THE PLANNING AND DELIVERY OF SUCH SERVICES.

59. THAT PERSONS OF INDIAN ANCESTRY BE ASSURED OF ACCESS TO ALL HEALTH, EDUCATIONAL AND SOCIAL SERVICES THROUGH GEOGRAPHIC DECENTRALIZATION AND THE REMOVAL OF CULTURAL AND SOCIO-ECONOMIC DETERRENTS. BAND COUNCILS AND INDIAN ELDERS SHOULD PLAY A SIGNIFICANT ROLE IN PROVIDING LOCAL INPUT REGARDING THE DELIVERY OF SUCH SERVICES.

60. THAT BOTH LEVELS OF GOVERNMENT JOINTLY FUND AN "INDIAN HEALTH, EDUCATION AND SOCIAL NEEDS ASSESSMENT STUDY" DESIGNED AND CONTROLLED BY PERSONS OF INDIAN ANCESTRY IN ORDER TO DETERMINE THEIR NEEDS FOR PSYCHIATRIC AND OTHER SERVICES.

61. THAT PREFERENTIAL HIRING PRACTICES, IN CONJUNCTION WITH AFFIRMATIVE ACTION POLICIES, BE IMPLEMENTED TO ENSURE THAT APPROPRIATE NUMBERS OF PERSONS OF INDIAN ANCESTRY ARE HIRED AND TRAINED TO DELIVER SERVICES TO THE INDIAN ANCESTRY POPULATION. SPECIAL "ON-THE-JOB" TRAINING SHOULD BE PROVIDED TO SUITABLE APPLICANTS AND MORE FLEXIBLE EDUCATIONAL AND EXPERIENTIAL PREREQUISITES SHOULD BE INTRODUCED.

62. THAT ALL PERSONNEL INVOLVED IN THE DELIVERY OF HEALTH AND SOCIAL SERVICES TO PERSONS OF INDIAN ANCESTRY SHOULD RECEIVE APPROPRIATE INSERVICE ORIENTATION AND TRAINING. THIS SHOULD BE GIVEN BY QUALIFIED PERSONS OF INDIAN ANCESTRY IN ORDER TO SENSITIZE MENTAL HEALTH PERSONNEL TO CULTURAL DIFFERENCES AND TO PROVIDE THEM WITH A BETTER UNDERSTANDING OF THE CONFLICTING ATTITUDES, VALUES AND BELIEFS WHICH SOMETIMES NEGATE THE EFFECTIVENESS OF SUCH SERVICES.

63. THAT ONGOING CONSULTATION WITH RELEVANT NATIVE ORGANIZATIONS SUCH AS A.M.N.I.S., F.S.I., THE NATIVE WOMEN'S ORGANIZATION AND FRIENDSHIP CENTRES BE ACTIVELY SOLICITED SO THAT THOSE RESPONSIBLE FOR THE PLANNING AND DELIVERY OF PSYCHIATRIC AND OTHER SERVICES TO PERSONS OF INDIAN ANCESTRY CAN ENSURE CONGRUENCE WITH THE AIMS AND IDEALS OF THE INDIAN PEOPLE AS EXPRESSED THROUGH THEIR ELECTED LEADERS.

64. THAT UNIVERSITIES, TECHNICAL SCHOOLS AND OTHER EDUCATIONAL INSTITUTIONS ENSURE THAT THEIR CURRICULA EMBODIES MATERIAL ABOUT THE NEEDS AND ASPIRATIONS OF THE INDIAN ANCESTRY POPULATION. CURRICULUM PLANNING SHOULD BE UNDERTAKEN IN COLLABORATION WITH PERSONS OF INDIAN ANCESTRY. EDUCATIONAL INSTITUTIONS SHOULD HIRE PERSONS OF INDIAN ANCESTRY TO BE INVOLVED IN THIS AND OTHER EDUCATIONAL PROCESSES IN THE TRAINING OF PROFESSIONALS FOR THE HUMAN SERVICES.

65. THAT FEDERAL DEPARTMENT OF INDIAN AFFAIRS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, IMPROVE THE LEVEL OF SUPPORT FOR ECONOMIC DEVELOPMENT ACTIVITIES ON RESERVES AND IMPROVE SOCIAL, RECREATIONAL, HEALTH AND OTHER HUMAN SERVICES. NO ONE SHOULD BE FORCED TO LEAVE THE RESERVE BECAUSE OF INADEQUATE SERVICES OR OPPORTUNITIES.

66. THAT BOTH LEVELS OF GOVERNMENT, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, ALLOCATE ADEQUATE FUNDS TO PROMOTE INDIAN SOCIAL, CULTURAL AND SPIRITUAL VALUES AND BELIEFS AMONG THE INDIAN ANCESTRY POPULATION. A BROAD BASED EDUCATIONAL PROGRAMME TO EDUCATE THE NON-INDIAN POPULATION ABOUT THE NEEDS AND ASPIRATIONS OF THE INDIAN ANCESTRY POPULATION SHOULD ALSO BE IMPLEMENTED.

67. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, ENSURE THAT HEALTH, EDUCATIONAL, SOCIAL FINANCIAL AND OTHER HUMAN SERVICES ARE MADE AVAILABLE TO ALL PERSONS OF INDIAN ANCESTRY IN A MANNER CONSISTENT WITH THE PROVISION OF SUCH SERVICES TO ALL OTHER MEMBERS OF SOCIETY.

68. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, SHOULD PLAN AND IMPLEMENT A PROGRAMME OF SUPPORT SERVICES FOR PERSONS OF INDIAN ANCESTRY RESIDENT IN URBAN AREAS SO AS TO ENSURE THOSE WHO FREELY CHOOSE TO LIVE IN AN URBAN ENVIRONMENT ARE ASSISTED IN ADJUSTING TO THIS ENVIRONMENT IN ALL WAYS POSSIBLE.

69. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS ACT IMMEDIATELY TO SETTLE OUTSTANDING INDIAN LAND CLAIMS, SINCE THE ECONOMIC STABILITY SUCH A SETTLEMENT WOULD BRING AND THE GOODWILL IT WOULD GENERATE COULD BE EXPECTED TO CONTRIBUTE TO THE IMPROVED MENTAL HEALTH OF THE INDIAN ANCESTRY POPULATION.

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VI(D) WOMEN'S ISSUES

At the outset of its deliberations, the Task Force became aware that there were a number of mental health issues unique to women which required special study. This led to the establishment of a Working Group on Women's Issues and to the development of its interim report. The research done by this group, which was a basis of that report, was supplemented by submissions both written and oral at the time of our public hearings. All of this forms the basis of our recommendations in this section.

Much of what can be said about mental health problems facing women is derived from studies done elsewhere in Canada and the United States. However, statistics available from Saskatchewan Health, its Psychiatric Services Branch and the Alcoholism Commission provided important regional data.

It has been demonstrated that Saskatchewan women receive more treatment for emotional disorders than do men by a ratio of 2:1. Furthermore, this treatment is more likely to be provided for minor emotional disorders (neuroses and psychosomatic illnesses) than for major disorders (psychoses, addictions, etc.). In addition, women are more likely to be prescribed psychoactive drugs such as tranquilizers and sleeping pills than their male counterparts, again by a ratio of 2-2.5:1. Recent reports from a youth services programme in Saskatchewan indicate that this prescribing pattern may be evident as early as ages 12 - 13!

Various factors were put forward to explain these patterns of high utilization and high consumption. It is stated that women, when experiencing emotional distress, for a variety of reasons appear more willing to consult a physician for help than do males. In the vast majority of cases the physician will be a general practitioner rather than a specialist. It was also pointed out that in the past medical education paid inadequate attention to the important contribution of social conditions to the genesis of illness. Another important contributing factor was identified as a societal dependence on chemical answers to problems of women. It was suggested that this has resulted in a combination of excessive prescribing on the part of physicians and excessive consumption on the part of patients. Finally, it was suggested

both by literature and submissions that the medical profession, predominantly male, has accepted the stereotype of the woman as being weak and more vulnerable to stress. It has been postulated that this is why women are more likely to be "labeled" as being "sick" and consequently being "treated".

On the other side of the ledger, there are some encouraging signs. Firstly, it was noted that there is increasing resistance on the part of the public to the unquestioning acceptance of psychoactive durgs. It was felt that the adverse publicity arising out of reports in professional journals and exposes in the public media are making both the medical profession and the public more cautious in their acceptance of the role of any tranquilizer in the treatment of minor disorders. Another encouraging sign is the increasing numbers of women who are entering the medical profession. It is hoped that this will result in bringing a greater degree of understanding to the women's role and the social stresses they face. Hopefully this will result in a diminished reliance on symptomatic treatment of women.

An important issue facing Saskatchewan women today is the increasing numbers joining the work force. At the time of the Task Force study, women constituted approximately 37% of the toal provincial work force. It has become apparent that an increasing number of Saskatchewan households are dependent on the wife's or mother's income to keep the family's standard of living above the poverty line. Despite the important contribution women workers make both to the economy of the province and the welfare of their families, they do so under conditions not faced by their male counterparts. Women are exposed to discrimination in pay, pensions, and other benefits. They face sexual harassment on the job and social harassment in the community for allegedly "neglecting" their primary responsibility. Many women have to manage two jobs in the face of inadequate daycare facilities. They end up doing double duty as wage earner and homemaker. An increasing number of them are doing so as single parents and thus they carry a particularly heavy burden. That such demands on women result in increasing fatigue and distress is hardly

surprising. The answer, however, lies not in labeling and treating women as patients but in identifying correctly those social factors that contribute to their problems of living and by so doing, take remedial steps.

A recurring concern expressed in a number of submissions and oral presentations to the Task Force was that of the tendency of the media in general and advertisers in particular to denigrate and demean the female role. It was pointed out that women in commercials and in dramatic productions are portrayed as servants, sexual objects, mindless victims and overwhelmingly as patients seeking help from an omniscient male doctor. These messages have become so powerful and pervasive in our society that it is not surprising that women learn to behave in these ways. Particularly disturbing has been the increasing acceptance of pornography by society. While not endorsing censorship, the Task Force is concerned about the negative and destructive images being portrayed through these materials. The Task Force is especially concerned that this information is increasingly available in the public domain and, thus, to our youth. We are concerned about the effect of this on their perception of their own sex role.

In order to address the concerns identified above, THE TASK FORCE RECOMMENDS THAT:

70. THERE SHOULD BE EQUAL PAY FOR EQUAL WORK.

71. SUBSTANTIALLY INCREASED FAMILY ALLOWANCES OR A GUARANTEED INCOME PLAN SHOULD BE INSTITUTED, ALLOWING WOMEN WHO PERFORM THE SERVICES RELATED TO RAISING AND NURTURING CHILDREN TO RECEIVE ADEQUATE REMUNERATIONS.

72. ADDITIONAL FUNDING SHOULD BE ALLOCATED BY THE DEPARTMENT OF HEALTH TO INCREASE VALUABLE PREVENTATIVE MEASURES:

    A) BY PROMOTING CONTINUING MEDICAL EDUCATION ON THE EARLY IDENTIFICATION OF HIGH-RISK PREGNANCIES AND THE PROVISION OF APPROPRIATE PRE-, PERI- AND POST-NATAL CARE.

    B) THROUGH MEDIA CAMPAIGNS TO PROMOTE WELL ESTABLISHED PREVENTATIVE MEASURES SUCH AS: COMPREHENSIVE VACCINATION, APPROPRIATE NUTRITION, PLANNING FOR PARENTHOOD, SEXUAL EDUCATION AND MONEY MANAGEMENT.

C) ALL WOMEN CONSIDERING ABORTIONS SHOULD HAVE THE RIGHT TO RECEIVE ASSISTANCE FROM THE COUNSELLOR OF THEIR CHOICE.

D) FUNDS SHOULD BE MADE AVAILABLE TO COMMUNITY-BASED ORGANIZATIONS THAT PROVIDE THE SERVICES AS IDENTIFIED IN (B) AND (C) ABOVE.

73. THE SASKATCHEWAN GOVERNMENT SHOULD ESTABLISH AN AUTOMATIC MAINTENANCE ENFORCEMENT PROGRAMME. THE GOVERNMENT OF SASKATCHEWAN SHOULD ASSUME THE RESPONSIBILITY FOR PAYING THE AWARDS WHEN THE EX-SPOUSES DEFAULT IN THEIR PAYMENTS.

74. TRANSITION HOMES SHOULD BE FUNDED ON A PROVINCE-WIDE BASIS TO PROVIDE SHELTER AND RESPITE TO VICTIMS OF SEXUAL OR PHYSICAL ABUSE.

75. EFFORTS SHOULD BE MADE TO ENCOURAGE WOMEN TO ENTER THE MEDICAL PROFESSION TO REFLECT THE GENERAL POPULATION STATISTICS. IN LINE WITH THIS, MEDICAL SCHOOL SELECTION COMMITTEES SHOULD BE SENSITIZED TO THE DESIRABILITY OF RECRUITING WOMEN TO TRAIN AS PHYSICIANS. RESIDENCY AND INTERNSHIP REQUIREMENTS SHOULD BE MADE MORE FLEXIBLE TO ACCOMMODATE FEMALE PHYSICIANS WHO WISH TO PURSUE THE DUAL ROLE OF PROFESSIONAL AND HOMEMAKER.

76. THERE SHOULD BE FUNDS ALLOCATED TO INFORM THE PUBLIC, LEGAL, MEDICAL AND SOCIAL WORK PROFESSION ABOUT THE ISSUES ASSOCIATED WITH RAPE AND PROVIDE ADEQUATE RESOURCES TO DEAL APPROPRIATELY WITH RAPE VICTIMS.

77. A CONCERTED EFFORT SHOULD BE MADE TO RAISE PUBLIC AWARENESS OF THE DANGERS INHERENT IN PORTRAYING NEGATIVE IMAGES OF WOMEN IN THE MEDIA AND THROUGH THE PERPETUATION OF STEREOTYPES. THE FOLLOWING ACTIONS SHOULD BE TAKEN:

A) THE C.R.T.C. SHOULD ENFORCE NON-SEXIST POLICIES AS A CONDITION OF GRANTING AND RENEWING LICENSES.

B) AS A PUBLICLY SUPPORTED NETWORK, THE C.B.C. SHOULD BE A LEADER IN PORTRAYING POSITIVE IMAGES OF WOMEN.

C) ALL PROVINCIAL AND FEDERAL ADVERTISING SHOULD PORTRAY POSITIVE IMAGES OF WOMEN AND BROADCAST COUNTER-SEXIST MESSAGES.

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VI(E) MENTAL HEALTH SERVICES FOR THE SPECIAL HANDICAPPED

A number of submissions to the Task Force questioned the adequacy of mental health services for those with special handicaps. Although most focused on the needs of the mentally handicapped, others were concerned about the adequacy of services for the physically handicapped and the sensorially impaired (e.g. hearing impaired)

Until 1973, the Psychiatric Services Branch was responsible for government programmes for the mentally retarded. In 1973, this responsibility was transferred to Core Services of the Department of Social Services. Prior to the transfer a beginning had already been made on the deinstitutionalization of services. In keeping with the so-called "normalization" approach, many residents of provincial institutions were placed in the community. This enabled them to gain access to educational, recreational and vocational rehabilitation programmes. Coincident with the decentralization of services, regional co-ordinators were established throughout the province. They functioned as consultants to the community and case managers to the mentally retarded (and their families) who required support services.

In many respects the transition from the Department of Health to the Department of Social Services was logical, appropriate and overdue. The majority of clients were neither mentally ill nor, indeed, suffering from any significant emotional disorder. What they required were not health programmes in the strict sense, but programmes designed to assist them to achieve their maximum potential in as normal a setting as possible. By removing them from the mental health system and from institutional-based care, it was hoped that the stigma associated with being a "patient" or a "resident" of an institution would be considerably reduced. As an added benefit it was hoped that the success in maintaining the mentally retarded in the community would lead to a greater tolerance and understanding by the community, thus, improving the climate for additional community initiatives.

For the most part, the transfer of this government programme worked extremely well. The number of individuals in the institutions was reduced and effective community-based programmes established. However, for a small number of mentally handicapped this change in jurisdiction complicated their existence.

It was brought to the attention of the Task Force that those individuals who become emotionally disturbed have on occasion had difficulty gaining access to mental health services. It was pointed out that they were frequently caught in a tug of war between the mental health system and Core Services. This was particularly true for those who were minimally handicapped but who presented with significant behavioural problems. Neither system appeared willing to accept the responsibility for these individuals. Because there are few residential alternatives available in the community, they frequently end up in an emergency department of general hospitals. Because of the lack of viable alternatives, they are admitted to acute care units; an inappropriate use of a scarce resource. This invariably leads to tensions between the two service agencies and not infrequently between the agencies and the client. In a majority of instances it would appear that the difficulties are caused by a lack of understanding of the roles of the respective service agencies in meeting the particular needs of individual clients. The Task Force believes that this is another example of the type of "problem" that must be resolved through a Regional Co-ordinating Committee.

A group of patients who experienced particular difficulty in gaining access to mental health services are those suffering from hearing impairment. They present a problem in that few mental health professionals are trained to work with the hearing impaired. Furthermore, there are so few of them, the demand for services has not justified a high priority in programme development. Yet if the principle of equal access is to apply to mental health services, then this group has the same right to health care as do other citizens. In view of the relatively small numbers involved, this would appear to be one instance where centralization of services would be legitimate.

It is important to have a small core of professionals competent to provide direct service to these clients as well as provide consultative services to others who work with them. ACCORDINGLY, THE TASK FORCE RECOMMENDS:

78. THAT A PILOT PROJECT SHOULD BE ESTABLISHED IN ONE OF THE MAJOR URBAN CENTRES TO DEVELOP PROGRAMMES FOR THE PROVISION OF MENTAL HEALTH CARE TO THE HEARING IMPAIRED.

It would be hoped that with the development of such a model programme its workers could be utilized as consultants to mental health programmes in other areas of the province.

Submissions from the two major Psychological Associations highlighted the need for the availability of mental health services throughout the entire health system. In support of their arguments, they cited studies indicating that the provision of certain mental health services by non-medical professionals results in a significant reduction in the pressure for services from the general practitioners and specialists. Examples were also provided where clinical psychologists have made important contributions to treatment programmes in such specialties as Orthopedics, Rehabilitation Medicine, Nephrology (renal dialysis), Oncology and Pain Management.

The fact that psychological factors play an important role in patients' (and families) reaction to illness and treatment has long been recognized. However, it is only in recent years that this knowledge has been put to use in inpatient and outpatient medical programmes. In recent years, the role of psychological factors in the successful management of renal transplant patients, coronary rehabilitation, mastectomy patients, burns victims, etc., has been accepted. As our hospitals, and particularly our tertiary care hospitals, are treating more people with greater degrees of pathology, there is a greater likelihood of psychological complications of treatment and rehabilitation. A successful outcome in many instances depends on the collaboration between a variety of health disciplines including Medicine,

Social Work, Psychology, Physiotherapy, Occupational Therapy and, indeed, the Clergy. These services may be provided while patients are in hospital or while being seen as outpatients or through Home Care Programmes. The essential point is that increasingly medicine is becoming multidisciplinary and that at certain stages in the patient's recovery, non-medical disciplines may be of paramount importance. This not only promises the opportunity for reducing the service load of medical professionals but may provide a more economical alternative.

The important role that mental health professionals can play in general hospitals is well established. Most major hospitals in Western Canada have recognized this and provide these services to their patients. In Saskatchewan, however, only the University Hospital provides these services to any significant degree. The Task Force is concerned that the need for these programmes has not been sufficiently understood by Hospital Administrators, Boards or indeed the Saskatchewan Hospital Services Plan. Therefore, THE TASK FORCE RECOMMENDS:

79. THAT THE SASKATCHEWAN HOSPITAL ASSOCIATION ESTABLISH A TASK FORCE CONSISTING OF REPRESENTATIVES OF MENTAL HEALTH PROFESSIONAL GROUPS AND THE SASKATCHEWAN HOSPITAL SERVICES PLAN TO LOOK AT THE CURRENT AND FUTURE ROLE OF MENTAL HEALTH PROFESSIONALS IN THE GENERAL HOSPITAL SYSTEM.

80. THAT THIS TASK FORCE BE ASKED TO ESTABLISH STAFFING STANDARDS FOR MENTAL HEALTH PROFESSIONALS IN MAJOR MENTAL HOSPITALS.

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VI (F) LAW & THE MENTALLY DISORDERED

INTRODUCTION:

Historically the legal and mental health systems in Saskatchewan have had a close if somewhat ambivalent relationship. Prior to the turn of the century in that part of the Northwest Territories which was later to become the Province of Saskatchewan, those mentally ill requiring protective shelter were housed in local police lock-ups. On July 20, 1885, a federal act was passed authorizing the Minister of the Interior to enter into an agreement with the Lieutenant Governor of the Province of Manitoba. This agreement enabled the transfer of insane persons from the Northwest Territories who were previously confined to Stoney Mountain Penitentiary, to the new Selkirk Lunatic Asylum. Even after the founding of the Province of Saskatchewan and the subsequent opening of the Provincial Hospital in North Battleford in 1914, the mental health and legal systems continued their close, but uneasy, relationship.

The fact that the law, and certainly the criminal justice system, should interface with mental health services is understandable if for no other reason than that they both have an interest in deviant behaviour. The basis for the frequent misunderstanding between representatives of the two systems may stem from their respective positions regarding deviant behaviour. Mental health systems are traditionally concerned about the health/welfare of the individual person or patient. The law and particularly the criminal justice system is primarily concerned about the welfare and safety of the public.

Mental health professionals may be involved in issues related to both criminal and civil law. In the criminal justice system, for example, psychiatrists, psychologists, etc., may be involved in pre-trial, trial and post-trial stages of criminal proceedings. An example of the interfacing of the two systems is covered by Section 23 of the Mental Health Act, which states:

> (1) *Where a judge or magistrate considers that a person apprehended and charged with an offence should be examined in a facility, he may order that that person be taken to a facility for examination as an outpatient after the medical officer in charge of the facility has been notified of the need of the examination.*

This section of the Mental Health Act establishes a procedure whereby sick individuals caught up in the criminal justice system may be diverted to the mental health system. Clearly, the use of this procedure will depend on a number of factors including the knowledge and sensitivity of the police regarding mental health problems as well as the quality of the relationship between the courts and the mental health system (in particular, the degree of mutual understanding and respect for their respective roles). Because these two systems, start out from opposing philosophical positions, there is obviously the need for continuing dialogue to ensure optimum understanding and co-operation. Whether this dialogue takes place will depend on a number of factors but especially the motivation of both parties, for there is no legal or administrative directive that makes such communication mandatory.

Briefs from various police forces in Saskatchewan confirm that law enforcement agencies are increasingly being called upon to deal with individuals exhibiting deviant and sometimes frightening behaviour. To the police these people are obviously mentally disordered and should be off the street. We were informed that the most common source of misunderstanding between the police and the mental health service system relates to the efforts of the police force to effect admission of such individuals to psychiatric facilites.

The submissions from police describe conflicts with mental health personnel over the issue of whether "apparently mentally disordered" individuals warrant admission to treatment facilities and, indeed, whether they are mentally disordered in the first place. They report many instances, where, after considerable difficulty a "patient" is taken to a psychiatric facility. There, they are informed that the "patient" is either not mentally ill, or that they are not"treatable". On either count, they are not eligible for admission to the facility It is understandable that these officers and their superiors are left with serious questions regarding the usefulness, or indeed the relevance, of our current mental health programme. It is not surprising, therefore, that the Task Force found a good deal of unhappiness

with the mental health services expressed by the police, the judiciary, the correctional services and other social agencies. The professional literature indicates that this is not peculiar to Saskatchewan but occurs across the continent and in the United Kingdom and, indeed, in any area where there has been a significant move towards deinstitutionalization.

There appeared to be at least two explanations for the current schism between the mental and legal systems. First, deinstitutionalization has resulted in a large number of mentally disabled individuals being maintained in the community. Secondly, in order to prevent "dumping" these individuals back into the hospitals, the mental health system has established stringent admission criteria. This has served to make it much more difficult to "commit" patients, particularly those who would not respond to acute care programmes. This policy has the advantage of protecting active treatment beds from being filled by "chronic" patients. However, it does shift the burden for the care of these individuals on to the community. Whether the community is able to cope with this burden will depend on the accessibility and availability of support services such as residential placements, vocational rehabilitation programmes, socialization programmes, etc. These programmes are essential to enable patients with continuing disability to function at their optimum level in a community setting. These are addressed in other sections of this report (Chapter V).

The second source of conflict may relate to the influence of the emerging patients' rights movement. Over the past decade, increasing concern has been expressed by patients' rights advocates about the infringement of the civil liberties of psychiatric patients by mental health systems. Strong patients' rights lobbies, have made a concerted attack on the traditional mental health system and, in particular, against mental health legislation. Although most of the ferment has occurred in the United States, the impact is beginning to be felt in Canada as well. Recent changes in mental health legislation in Ontario indicate a radical departure from the traditional powers and authority accorded mental health professionals and the mental health system. Although Saskatchewan to date has remained remarkably isolated

from these movements and changes, nonetheless, it is apparent that mental health professionals have become increasingly sensitive to patient rights issues. Attitudinal changes would appear to be reflected in the practises, if not the policy, of the mental health system in that psychiatrists in particular are increasingly reluctant to invoke civil commitment. Furthermore, psychiatrists appear to be respecting the wishes of patients as to whether or not they want treatment. This only adds to the difficulty a community faces in disposing of those individuals who "appear" mentally disordered. The advent of deinstitutionalization and restrictive legislation have combined to erect a substantial barrier to the "diverting" of some bothersome members of the community into the mental health system.

It was apparent to the Task Force that there was limited understanding on the part of the criminal justice system of the current mental health policy and especially the rationale behind the deinstitutionalization movement. It was also clear that there was a need for closer liaison at both the provincial and regional levels. In view of the fact that the Ad Hoc Committee Report of 1966 identified this as one of the major issues underlying the controversy over deinstitutionalization, it was at a loss to understand why this recommendation has not yet been implemented some 16 years later.

The Task Force feels that community acceptance and involvement in psychiatric programmes requires knowledge and understanding of what these programmes are and what benefits the community will derive from them. Public education will be discussed in another section of this report and specific recommendations will be detailed therein.

THE TASK FORCE STRONGLY RECOMMENDS:

81. THAT AMONG THE VARIOUS HUMAN RESOURCE AGENCIES INVOLVED WITH THE "APPARENTLY MENTALLY DISORDERED" INDIVIDUALS, A MECHANISM BE ESTABLISHED TO IDENTIFY CLEAR POLICIES, PROCEDURES AND ACCOUNTABILITY STRUCTURES.

In meeting with Directors of a number of Correctional Centres, strong criticism was voiced about the lack of mental health services to this particular population. The Provincial Correctional Services rely on their colleagues in the Psychiatric Services Branch to meet the mental health problems of their inmates. However, because of an inadequate number of available staff in regional psychiatric centres, many programmes receive a minimal service. What services were provided were generally well received although it was recognized that due to the nature of the service little in the way of continuing programmes could be provided. The Directors of the Correctional Centres were convinced that the paucity of services was more a reflection of the manpower problems of the Psychiatric Services Branch than a lack of interest or co-operation.

Over the past years, the legal profession, the Attorney General's Department and the courts have bemoaned the lack of availability of psychiatrists interested in forensic issues. Private psychiatrists find court work too disruptive to their practise and thus, apart from one or two individuals, tend to shun it. Public sector psychiatrists are equally unenthused about spending their valuable time in courts when there are so many competing demands for their services. Traditionally, University programmes have been seen as a source for this service; however, the Department of Psychiatry has been unable to sustain a formal forensic service over the years that it has been in existence. Although it has recently obtained the service of a fulltime forensic psychiatrist, his time has already been over-committed simply in meeting the needs of the Saskatoon Catchment Area.

The lack of a formal programme in the University Department of Psychiatry has had a significant effect on the training experience of its Psychiatric Residents. The result is that those who have graduated from the programme have not been motivated in pursuing either a career in forensic psychiatry nor, indeed, taking a major interest in this area. Forensic psychiatrists remain a rarity in psychiatry and thus Saskatchewan must compete with other centres such as Toronto, Calgary and Vancouver. It is obvious that for a variety of reasons we have not been competitive and, that undue reliance on attracting forensic specialists from other centres will continue to be unrewarding. The logical

long-term solution is the establishment of a training programme at the University of Saskatchewan in which the facilities of the Regional Psychiatric Centre might serve as a clinical teaching base. This will depend on the acquisition of additional teaching staff for the Department as well as the accreditation of the Regional Psychiatric Centre in order that it may be used as an affiliated teaching institution.

One of the curiosities of the Task Force proceedings was the relative absence of comment about current mental health legislation. This seemed paradoxical in view of the publicity given to patients' rights in the recent deVlieger Report which devoted a special chapter to mental health issues. The Task Force had anticipated submissions on mental health legislation and, therefore, was understandably surprised when none was forthcoming. It may have been that the activities of the Saskatchewan Law Reform Commission in this area led the public to assume that this issue was being addressed elsewhere. In view of the lack of submissions as well as the current activities of the Law Reform Commission, the Task Force will not make recommendations regarding this.

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VI(G) PERSONS IN GEOGRAPHICALLY ISOLATED AREAS

In a Canadian context, Saskatchewan is unusual in that while its population is dispersed over a large geographic area, it is relatively evenly settled. Although the province is rapidly becoming urbanized, only three of every five of its citizens live in centres with populations in excess of 1,000. Rural mental health services are particularly important in Saskatchewan because of its geography and relatively large rural population.

The Department of Health's Thrust Working Party on Community Based Alternatives for Mental Health Care (1980) identified the principle of accessibility - "a full range of direct and supportive mental health services of good quality should be available to all residents as close to their home communities as possible." - as being of first importance. In an effort to improve accessibility, services are being progressively decentralized. At the present time there are resident staff in 16 communities and services are extended to an additional 60 communities on a regularly scheduled basis. At the same time, it has become much easier for rural residents to travel to larger centres in order to receive services. In most ways efforts to improve accessibility appear to have met with some success. For example, in an investigation of the relationship between place of residence and service utilization, Silzer (1981) found no significant difference between the relative number of mental health services used by rural and urban residents.

The Task Force was informed that the regionalization of services in Saskatchewan has been only partly successful. While, as it was noted above, the statistics would suggest that there has been considerable success in providing total numbers of services, there has been less success in providing a full range of services.

Because of chronic fiscal difficulties, combined with problems of recruitment and retention of qualified staff, full development of these regional programmes has not taken place. A major problem has been the apparent unwillingness of well qualified staff to locate in smaller centres. As a consequence, rural regions tend to experience a relatively high turnover in staff which, in turn,

has an impact on the continuity of programmes. Of special concern has been the lack of adequate services to particular population groups in smaller centres - the young, the elderly, the handicapped and those who reside in nursing homes.

The problem of servicing rural or isolated regions is, of course, not unique to Saskatchewan. It besets Ontario, the Territories and Prince Edward Island to name just a few. In many ways the situation resembles the dilemma facing McKerracher in the late 1940's when he was unable to attract Registered Nurses to Weyburn or to North Battleford. McKerracher's solution was, at the time, unorthodox. Specifically, he trained his own special type of psychiatric nurse. This nurse, of course, is now well established and, in the Prairie Provinces, well accepted.

With the precedent of the Registered Psychiatric Nurse in mind, the Task Force suggests that it is time for another initiative. It suggests that consideration be given to the development of a new type of mental health worker, the "Rural Mental Health Practitioner".

The concept of the rural mental health practitioner was not well received by the professional groups who reacted to our Interim Report. In our opinion the negative response was due to a lack of understanding of the nature of this new professional. We fully accept the responsibility for this as obviously we had not described the concept as clearly as we should have.

The Rural Mental Health Practitioner, with basic training in nursing, will require additional knowledge and skills. Specifically, the person should be thoroughly familiar with community resources and demonstrate an ability to work effectively with various professionals found within a community (e.g. physicians, teachers, clergymen, etc.). The person should have received some training in counselling and possess good interpersonal skills. The person should have a good basic knowledge of psychopathology and to be able to recognize (but not diagnose) psychological disturbances. The person should have a sufficient knowledge of physiology and psychopharmacology to enable them to monitor the effects of psychoactive medication and particularly to

detect side effects. Their nursing skills should enable them to administer medication and provide other treatment under a doctor's orders. The person should possess psychiatric nursing skills necessary to enable them to consult to hospital and nursing home staff regarding patients exhibiting disturbed behaviour. Most importantly, the person must know when to seek assistance from other mental health professionals and where such assistance can most readily be obtained.

The professional described is the psychiatric nursing equivalent of a nurse practitioner. Given the appropriate training, we believe that people can be equipped with the requisite skills. The level of training is likely to equal that received by persons completing four-year baccalaureates. Nursing, specifically psychiatric nursing, will form the core of the training programme but this would be augmented by additional instruction in areas such as psychology and social work. Remuneration would be based on the level and extent of training required.

The creature we are describing obviously does not exist at the present time and it would be premature to embark on a large scale training programme without first testing the viability of the concept. We recommend that a detailed syllabus based on existing course offerings be defined and that a pilot project involving approximately five to ten trainees be undertaken. Consideration might reasonably be given to ways in which nurses currently resident in smaller communities might be equipped with the requisite skills to enable them to function as rural mental health practitioners.

THE TASK FORCE RECOMMENDS:

82. THAT THE SASKATCHEWAN DEPARTMENT OF CONTINUING EDUCATION IN CONJUNCTION WITH PSYCHIATRIC SERVICES BRANCH, ESTABLISH A DEVELOPMENTAL TRAINING PROGRAMME FOR RURAL MENTAL HEALTH PRACTITIONERS.

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VII (A) EDUCATION, PREVENTION AND RESEARCH

Public education is one preventive strategy that received universal support. It was generally accepted that there was a need to change public attitudes toward mental illness and the mentally ill. It was the consensus of many briefs that mental illness still carries a stigma with it and that this stigam represents a serious impediment to the development of a comprehensive community mental health service. A recent study by D'Arcy would suggest that in spite of the increasing exposure of the public to mental health issues through educational programmes, the media, movies and the theatre, there has been little evidence to indicate that the stigma historically associated with the mentally ill has been effected to any significant degree.

Although much lip service is given to the role of education in mental health programming, mental health education is given little attention in Saskatchewan. The Department of Health has attracted well deserved praise for its "Aware" and 'Feeling Good" programmes. These educational programmes and others directed at the hazards of smoking are highly visible and have undoubtedly affected the attitudes, if not the behaviour, of Saskatchewan citizens. In sharp contrast to this, however, is the almost total absence of any health promotion directed at the need for developing appropriate coping mechanisms for stress.

The Annual Reports of the Department of Health indicate that the Psychiatric Services Branch is responsible for carrying out activities related to "health promotion". These reports, however, fail to reveal any evidence of a systematic approach to this. Given the preoccupation with increasing service demands and manpower shortages, public education gets a low priority. It is clear that there is a major job to be done not only in acquainting the public (and other human resource agencies) about the programmes and policies of the Psychiatric Services Branch but also for promoting better lifestyles.

The Task Force feels that this educational programming should not be tacked on to the everyday responsibilities of professionals involved in direct services. They are already over-committed. This reality has been recognized by the Alcoholism Commission of Saskatchewan which has established an autonomous education division with the sole responsibility for carrying out these activities. The Alcohol Commission recognizes that education is not a part-time activity and that to be effective, programmes must be well researched, designed and implemented. This calls for a level of expertise which is generally not possessed by service workers. The Task Force agrees with this approach AND RECOMMENDS:

83. THAT THE PSYCHIATRIC SERVICES BRANCH ESTABLISH AN EDUCATION AND HEALTH PROMOTION DIVISION TO INCREASE PUBLIC AWARENESS OF MENTAL HEALTH ISSUES AND MENTAL HEALTH PROGRAMMES.

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VII(B) PREVENTION

No one issue evoked more conflicting and strongly stated opinions than that of the role of prevention in the future planning of mental health services. Many briefs touched upon this issue. Of these, few were neutral, the majority either being strongly critical or supportive. The reasons for disagreement were varied. For some, it appeared to be a question of professional territoriality (i.e. the so-called "psychosocial model" versus the "medical model"). For others, it was based on a concern that focusing on primary prevention programmes would only serve to divert scarce funds away from existing treatment programmes. However, the most common basis for disagreement would appear to have been differing interpretations of the meaning of what constitutes "mental disorder" and because of that, different expectations of the mental health system. For those who saw the major thrust of mental health programming to be the promotion and maintenance of "health" versus the treatment of "illness", prevention assumed a greater significance. Others, particularly those involved with treatment programmes (e.g. nurses, psychiatrists) placed greater emphasis on the need to expand and develop treatment strategies, thus relegating prevention to a subsidiary role.

The Task Force's dilemma is illustrated by two companion articles which appeared in Hospital & Community Psychiatry, Vol. 32, No. 12, December 1981, pp. 839-848. These papers represent the two opposing philosophical positions regarding the role of primary prevention in the field of mental health.

In an article entitled, "The Logic and Urgency of Primary Prevention", Bernard L. Bloom, Ph.D., Professor of the Department of Psychology, University of Colorado, concludes:

> *The need for mental health services now far outstrips the availability of mental health professionals and likely will continue to do so for the foreseeable future. The growing awareness of this mismatch is partially responsible for the renewed hopes of effective primary prevention. In this context a recommendation of the President's Commission on Mental Health seemed prudent, appropriate and timely. These recommendations - for the establishment of a centre for prevention within NIMH, the development of special programs directed toward children at*

> *risk, and the development and evaluation of services and programs designed specifically for times of significant life stress - deserve the active support of all mental health professionals and professions. If we insist on waiting until all direct treatment needs are met before allocating resources to prevention, we will doom our professions to continuation of the hopeless spiral we are now in. Of course, we may have to divert some money from direct treatment to undertake a significant effort in the field of primary prevention; yet, when we consider the total cost of mental illness to our society, that resource diversion is not only trivial, but in fact represents one of the few hopes we have for ultimately controlling a major source of human suffering.*

Authors H. Richard Lamb, M.D., and Jack Zusman, M.D., Professors of Psychiatry at the University of Southern California School of Medicine, in their article, "A New Look at Primary Prevention", conclude:

> *Because of primary prevention's appeal, mental health professionals might use it as a glamorous rationalization for avoiding treatment of difficult patients, such as the chronically psychotic, the alcoholic, and the addicted. This phenomenon has helped tarnish the image of community mental health in the eyes of many legislators, administrators, clinicians, and the general public. Sound, well conceived research in prevention based on controlled studies is sorely needed, but ought to be funded separately from direct treatment programs. Research in program evaluation, when properly carried out, are so expensive that such studies cannot be grafted onto existing programs as "minor" additions. The prevention of mental illness is a vitally important goal and we fully support generous funding of research to reach it. We do advocate, however, that applied programs, except on a pilot basis, await the outcome of further research.*

It is not surprising then, that the Task Force, faced with such persuasive but conflicting arguments had great difficulty in reaching a consensus. While it is true that the "interventionists" and the "therapists" on the Task Force undoubtedly reflected the bias of their professions, nonetheless they made an honest attempt to reach a consensus. It would be fair to say that the recommendation of the Task Force regarding primary prevention represents a compromise. Like most compromises, it is not totally satisfactory. However,

it does represent a position that the Task Force feels is realistic, achievable and desirable.

In arriving at our recommendation, the Task Force was mindful that the current manpower resources in our mental health system are so thinly stretched that to add additional burdens on them, or indeed to divert scarce professional resources from existing programmes, would place our system in serious jeopardy. For this reason, the Task Force strongly supports the position that supplementary funding be provided to support primary prevention programmes in the mental health field.

The Task Force was mindful of the fact that since the publication of the Hon. Marc Lalonde's "New Perspective on the Health of Canadians", governments across the land would appear to have climbed on the prevention "bandwagon" as an answer to the spectre of spiralling health care costs. We were also mindful of the fact that their widely publicized support for these strategies has not as yet materialized in the form of significant financial support. The Task Force was cognizant of the competition for scarce health dollars, yet feels firmly committed to the need to develop an initiative in the area of primary prevention. Given these considerations, THE TASK FORCE RECOMMENDS:

84. THAT THE GOVERNMENT RECOGNIZE THE IMPORTANCE OF DEVELOPING PRIMARY PREVENTION STRATEGIES IN THE AREA OF MENTAL HEALTH BY PROVIDING SUPPLEMENTARY FUNDING TO ENABLE THE ESTABLISHMENT OF PILOT PROJECTS UNDER THE AEGIS OF BOTH GOVERNMENT AND NON-GOVERNMENTAL AGENCIES.

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VII(C) RESEARCH

A few short decades ago diseases such as smallpox, typhus, cholera, malaria, diptheria, tuberculosis and polio caused untold misery to mankind both by death and disability. Research, however, led to their virtual eradication and resulted in saving of countless lives and billions of dollars in health care costs. The research required to achieve this included both basic and applied. A recent example of the application of applied research was the identification of the link between smoking and lung cancer which was only uncovered after epidemiological studies on literally millions of people. The role of basic research is best illustrated by Fleming's serendipitous discovery of the antibiotic penicillin. Thanks to his efforts and the subsequent discovery of a variety of other antibiotics, the effectiveness of modern medical treatment was dramatically increased.

The role of research in the field of mental illness has historically lagged behind that of general medicine. Significant achievements have been made however, in the understanding of certain mental disorders such as pellagara, neurosyphilis, phenylketonuria - to name a few. These discoveries led not only to the cure but to the prevention of such disorders. Until recently the major psychiatric disorders (e.g. schizophrenia, affective disorders, alzheimer's desease, etc.) have eluded our understanding but advances in biomedical research have shed more light on brain functioning, leading to a better understanding of the relationship, of neurotransmitters, to normal and abnormal mental functioning. This research has only been possible through a multidisciplinary effort and major developments in research technology.

The introduction of the mass spectrometer, nuclear magnetic resonance (NMR), positron emission tomography (PET) and the CAT scan have expanded the frontiers of neuroscience research. These instruments, sophisticated and costly as they may be, are essential tools in future research projects if we are to expand our knowledge to the point where we will unravel the mystery of the major psychiatric disorders which remain the number one mental health problem today.

In the past Saskatchewan has played a leadership role in psychiatric research primarily because of the work of the Research Division of the Psychiatric Services Branch. The contribution of this division to mental health research (both basic and applied) has been recognized at national and international levels. Saskatchewan today, because of its experience in the field, its established research competence and access to extensive computerized data banks, is in an excellent position to continue and to extend its leadership role. The Task Force noted that current studies underway include: the evaluation of service delivery and service outcome, patterns of care; biopsychosocial predictors of psychiatric vulnerability; and, the fundamental studies on the role of amine substances in the propagation of nervous impulses. These examples indicate the breadth and scope of research currently being undertaken by this provincial group. The potential benefits of this research are obvious; the need to maintain this high level of productivity is also obvious.

In addition to the above achievements, there are equally important spin-offs of the research activities of this division. As a result of its international reputation based on its research achievements, the division has attracted a number of its students from across the world who aspire to a career in mental health research. This training programme, in conjunction with the Department of Psychiatry of the University of Saskatchewan, has developed into one of the larger graduate training programmes on the campus. The result is not only the production of much needed mental health researchers but also additional research programmes. The province and the mental health system are both beneficiaries of this additional activity.

The Task Force recognized the significant contributions made by the Research Division in the past and its potential for future achievements. It also recognizes the essential role that this division plays in our mental health system and, THEREFORE STRONGLY RECOMMENDS:

85. THAT THE PROVINCIAL GOVERNMENT RECOGNIZE THE IMPORTANT ROLE OF RESEARCH IN A COMPREHENSIVE MENTAL HEALTH SYSTEM AND THAT IT MAINTAIN AND STRENGTHEN ITS SUPPORT OF THE BIOLOGICAL AND APPLIED RESEARCH PROGRAMMES OF ITS PSYCHIATRIC SERVICES BRANCH.

The centralization of the research activities of Psychiatric Services Branch has undoubtedly had positive effects in terms of maximizing resources and in the co-ordination of programmes. An unforeseen cost, however, has been the gradual disappearance of clinical research activities in the regional centres such as Regina, Weyburn, Moose Jaw, Yorkton, etc. Whereas at one time, small but active research projects were carried out in these regions, there is little evidence that this has taken place over the last decade. The explanations given for this were that budget and manpower limitations precluded the possibility of continuing in these activities. The Task Force regrets this development inasmuch as it sows the seed for professional stagnation which in turn could affect the quality of service. THE TASK FORCE RECOMMENDS:

86. THAT THE PSYCHIATRIC SERVICES BRANCH PROMOTE REGIONAL RESEARCH ACTIVITIES THROUGH THE PROVISION OF FUNDING FOR CONSULTATIVE SERVICES AND THE RECOGNITION OF THIS AS A LEGITIMATE PROFESSIONAL ACTIVITY.

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VII(D) EVALUATION OF MENTAL HEALTH SERVICES

Evaluation is an essential component of any well managed mental health service. Rational decision making requires reliable and valid information about the service and its impact. It is necessary to know where you are as well as where you want to go in order to constructively provide and manage services. In the most basic sense, we use the term evaluation to refer to those activities that enable us to determine where we are in relation to where we would like to be.

Evaluations in mental health settings are conducted for a variety of reasons and at a number of different levels. Anderson and Ball (1978) suggest five reasons:

1) to contribute to decisions about programme installation;
2) to contribute to decisions about programme continuation, expansion or certification;
3) to contribute to decisions about programme modification;
4) to obtain evidence to rally support for a programme; and
5) to obtain evidence to rally opposition to a programme.

Particular evaluations may be approached as formal enterprises requiring a significant investment of time and resources, while other evaluations may be undertaken on a casual basis. Individual therapists seeking to improve their own effectiveness may attempt to evaluate their own practices, while executive personnel in the Department of Health may be concerned with the effectiveness of entire service systems. Whatever the reason and whatever the level, evaluations tend to take a particular form. Information is collected to facilitate a comparison between something that exists, and a standard against which it might reasonably be judged.

Standards may take a number of different forms. Accreditation procedures are normally premised on elaborate prescriptions relating to both structural and operational features of organizations. Legislative mandates may be very general (eg. the Psychiatric Services Branch authorization to provide community mental health services) or fairly detailed (eg. procedures

governing involuntary admissions to psychiatric inpatient facilities). In many instances, well defined external standards are not available. In these instances, evaluation frequently depends on comparisons involving programmes with similar objectives in related, but different, settings. Averages are frequently used as a basis for comparison. Another technique that is often employed involves the use of explicitly stated expectations.

Saskatchewan's mental health services have a somewhat spotty record insofar as evaluation is concerned. The Applied Research Division of the Psychiatric Services Branch has conducted a number of studies over the year. These have been particularly valuable in describing the utilization of mental health services. The central office of the Branch has maintained an evaluative capacity in the form of a computerized information system, yet in the opinion of many, the potential of this system has never been fully exploited. The Regional Psychiatric Units and the Psychiatric Wards in General Hospitals are periodically evaluated as part of a regular accreditation review by the Canadian Council of Hospital Accreditation. In addition to this, particular facilities have chosen to evaluate specific programmes from time to time. However, in reviewing the total picture, the Task Force concluded that evaluation in sofaras the Psychiatric Services Branch is concerned, has never been given a high priority. As a result, both financial and manpower resources have never been made available to support an ongoing systematic evaluative effort.

In order to ensure that the overall mental health system is adapting to changing needs in service pressures and is meeting them in an effective, efficient fashion, a more formalized and systematic approach to evaluation of our mental health programmes is indicated. In order to achieve this, THE TASK FORCE RECOMMENDS:

87. THAT 3% OF ALL MENTAL HEALTH BUDGETS (GOVERNMENTAL AND NON-GOVERNMENTAL) BE DESIGNATED FOR THE USE OF ESTABLISHING FORMAL EVALUATIVE PROCEDURES.

88. THAT IMPROVEMENT IN THE EVALUATIVE PROCESS BE MADE IN FOUR GENERAL AREAS:

    (1) INCREASING THE CAPACITY FOR EVALUATION OF THE SMALL PROGRAMME AND TO INDIVIDUAL WORKER LEVEL;

(2) ESTABLISH THE ROUTINE EVALUATION OF MAJOR PROGRAMMES;

(3) ENSURE THE DEVELOPMENT AND ROUTINE APPLICATION OF QUALITY ASSURANCE MECHANISMS IN ALL PROGRAMMES; AND

(4) TO ENSURE THE MONITORING AND EVALUATION OF THE TOTAL SERVICE DELIVERY SYSTEM ON AN ONGOING BASIS.

At the small programme and individual worker level, we recommend that evaluation formally be recognized as a legitimate activity. Local personnel should be encouraged to regularly examine the effectiveness of their activities and should receive some assistance in doing so. Appropriate assistance can be provided by giving the staff access to external consultants (eg. from the universities) and by making modest sums of money available to provide materials, employ casual staff, and pay for data analysis.

We recommend that all major programmes; programmes with associated costs in excess of $250,000 per year; be evaluated on a regular basis. All such programmes should be evaluated at least once every five years with new programmes and programmes subject to change being evaluated more frequently. Such evaluations are best conducted by persons with no direct ties to the programmes being investigated. For this reason we suggest that such evaluations be contracted for with the universities and with private consultants and that costs be borne by central agencies or their equivalents (eg. general hospital boards).

The development and application of quality assurance mechanisms is an area that we regard as particularly important. We strongly recommend that all mental health facilities continue to make use of the standards developed by the Canadian Council on Hospital Accreditation and that all facilities be required to be accredited. We recommend that standards of practice for the professions be developed and that they be mandated. We also recommend that the work of all mental health professionals be reviewed on a periodic (at least once every three years) basis by audit committees established for

this purpose. Such committees should be comprised of working professionals. Representatives should be drawn from a number of facilities and agencies with the proviso that no professional be involved in reviewing staff activities in his or her own facility.

The Task Force recommends that the larger mental health system be monitored and evaluated on an ongoing basis. Statistics relating to system parameters such as: inpatient and outpatient service rates; the age, sex, ethnic, and geographic distribution of persons receiving services; admission and re-admission rates; average lengths of stay in inpatient facilities by diagnosis; numbers of involuntary admissions by facility; and the distribution of resources in relation to numbers of persons receiving services -- should be maintained and reviewed on an ongoing basis. The Task Force recommend that the existing capacity in the Psychiatric Services Branch be maintained and expanded. An audit committee with representation from the Deputy Minister of Health's office, the Psychiatric Services Branch, and the University Hospital's Department of Psychiatry should be established to review the systems' functioning on a semi-annual basis.

One final point needs to be reinforced before the topic of evaluation is left. Evaluations are intended to provide practitioners and managers with necessary information about the consequences of their actions. Evaluation assists in the identification of the positive as well as the negative aspects of programmes and will ideally assist all personnel in their efforts to do a better job.

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Reference:

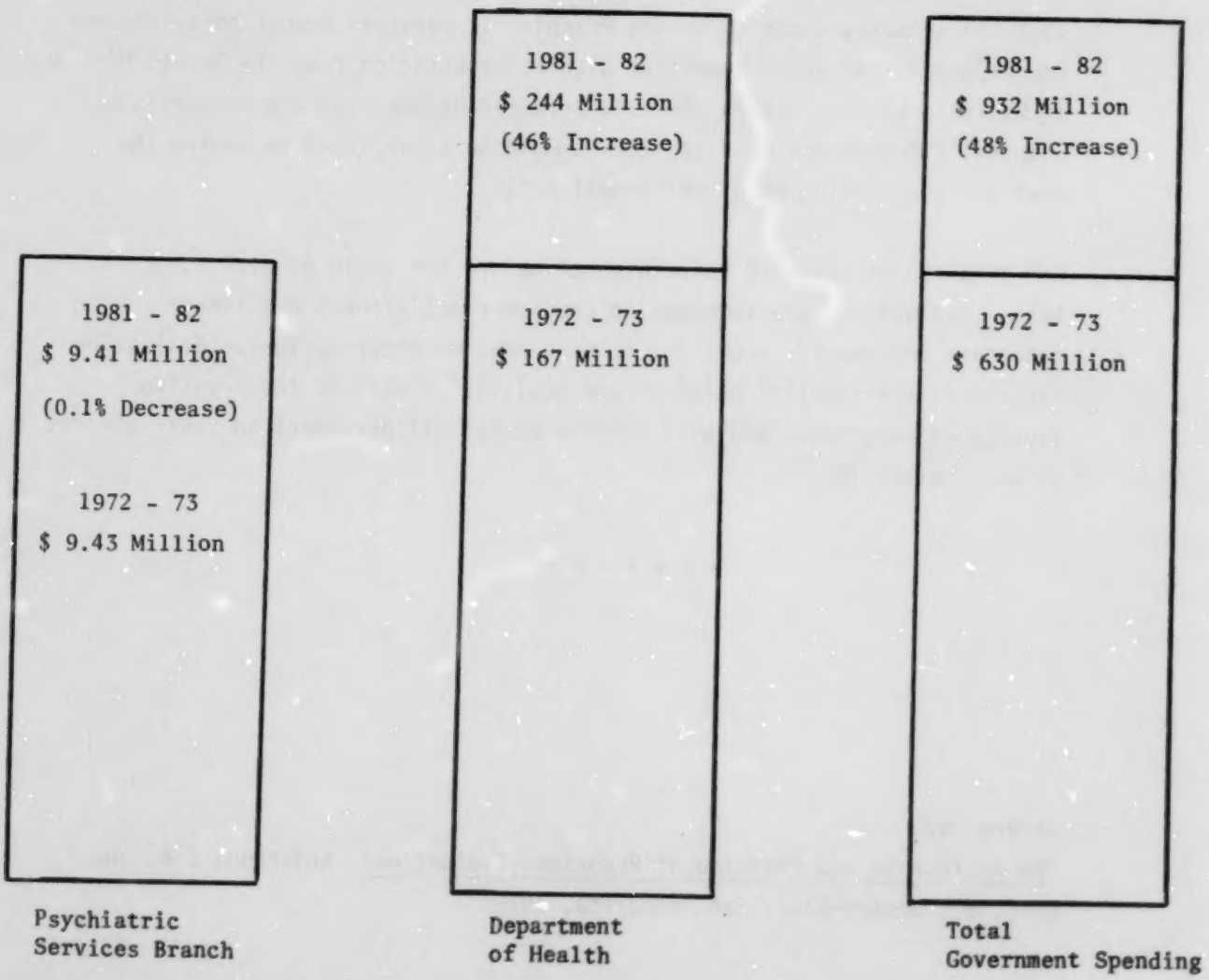
The Profession and Practice of Programme Evaluation: Anderson, S.B. and Ball, S., Jossey-Bass, San Francisco, 1978.

VIII (A) FUNDING AND MANPOWER

A recurring criticism throughout the whole review of existing mental health services in Saskatchewan was that of underfunding. In a submission made to the Ministers of Health, Education and Social Services on November 3, 1981, the Mental Health Association observed that "funding for mental health services appears to be declining both as a proportion of total provincial government spending and even in constant dollars".

(figure #1)

PROVINCIAL SPENDING
1972-73 to 1981-82
(Expressed in 1971 DOLLARS)



Source: Public Accounts And Province Of Saskatchewan Estimates

In comparing the expenditures of the Psychiatric Services Branch to the Department of Health and its total government spending, the Mental Health Association noted that over the period 1972-73 to 1981-82, the Psychiatric Services Branch funding actually decreased by 0.1% in 1971 dollars (fig. #1). During the same period the budget for the Department of Health increased by 46%, whereas total government spending increased 48%. For four budget years in that time span, the budget increases for the Psychiatric Services Branch were lower than the rate of inflation (meaning that there was an actual reduction in the amount of money available for the treatment of the mentally ill). It is obvious that the expansion of Health and other government programmes has taken place at the expense of the public mental health services.

This economy in Psychiatric Services Branch spending has been achieved mainly through a decrease of 142 positions in the eight years from 1972-73 to 1980-81, representing a total reduction of 14.5% of the staff. This situation has taken its toll in terms of staff turnover, with an alarming turnover rate in Regional and Headquarter management positions as well as the previously mentioned high turnover rate among psychiatrists, psychologists, social workers, etc. An even more graphic illustration of the decline in funding for Psychiatric Services Branch can be seen in the comparison between the costs of the mental hospital based mental health service compared to the current regionalized programming.

In the early 1960's, the two provincial hospitals at Weyburn and North Battleford reached a peak of 4,500 patients. These hospitals had been showing a steady increase in their inpatient census. If, however, that census had remained stable over the ensuing 20 years, the cost of maintaining 4,500 patients in the two provincial hospitals can be estimated (using the $95. per diem rate at Brandon Mental Hospital - 1981) at $157 Million per annum.

Since the phasing out of the two mental hospitals and the regionalization of services, funding for mental health programmes comes through a variety of sources. The Psychiatric Services Branch budget continues to be

the largest source of funding; however, this is followed by S.H.S.P., M.C.I.C. and Pharmacare. For the budget year 1981, the following costs could be identified:

1. S.H.S.P. - $12,896,000. This is for all inpatients with a primary psychiatric diagnosis. This would include those patients being treated by G.P.'s, private psychiatrists and University Hospital psychiatrists.

2. Psychiatric Services Branch - $23,869,000. This includes grants to Saskatchewan Mental Health Association as well as other organizations providing community programmes.

3. M.C.I.C. - $2,811,000. Billing for psychotherapy.

4. Pharmacare Plan - $5,723,000. This covers central nervous system drugs.

Not identified in these figures are Social Assistance Payments (SAP) and Level IV Care costs. (Some Level IV patients would previously have been housed in North Battleford and/or Weyburn.)

The total identifiable costs for the year 1981 are $45,299,000.

The above noted figures are obtained from the Public Accounts. Granted they are, at best, a rough estimate of the true costs of providing health services; nonetheless, even if they address only 50% of the true costs, this would still represent a saving in excess of $50 Million annually.

Funding issues were central to many if not most of the problem areas identified by the Task Force. Whether one looked at Manpower, Children & Youth, The Elderly,or Pevention - the main obstacle common to all was insufficient funding.

Suggestions that health programmes are underfunded usually elicit what has become almost a reflex response from government. It is generally put forth that the question is not the need for additional funding but more efficient use of existing funds. It is suggested that by tightening up

organizational structures, thus reducing wasteful duplication and overlap, that major economies can be effected.

The Task Force does not question that duplication and overlap exists within our current mental health system. This point was made in a number of briefs, however it is inconceivable that reorganization alone will free up enough funds to meet existing programme needs let alone those we have recommended for the future.

The evidence indicates (fig. 2) that the demands for services will continue to increase. In 1980, Psychiatric Services Branch statistics indicate that some 9.6% of the total population in Saskatchewan received help for a psychiatric problem. This is projected to increase to 10.1% of the population by year 2001. These figures related only to services delivered, not to identified needs. We were informed that at least an equivalent number of people have identified themselves as in need of professional assistance but for a variety of reasons have not received it. Clearly, any programme directed at increasing self-awareness could produce an additional service burden which existing programmes could not accommodate.

The real test of any government's commitment to a programme is what recognition they give it through the budgetary process. Budgetary allocations over the past 10-15 years would certainly suggest this commitment to be minimal!

Only a cynic would suggest that the underlying reason for deinstitutionalization is to effect a saving in tax dollars; nonetheless, these figures would suggest that funds that once would have been allocated to mental health services have been channeled into other areas of government activity. The fact that this situation has been allowed to develop is not simply an indictment of the succession of governments but also of a society that will allow these practises to go unchallenged. This sorry state of affairs is the strongest argument for the establishment of an effective advocacy movement for the rights of the mentally ill. THE TASK FORCE RECOMMENDS:

89. THAT GOVERNMENT IMMEDIATELY ALLOCATE AN EQUITABLE SHARE OF HEALTH FUNDS TO THE MENTAL HEALTH PROGRAMMES IN THE PROVINCE.

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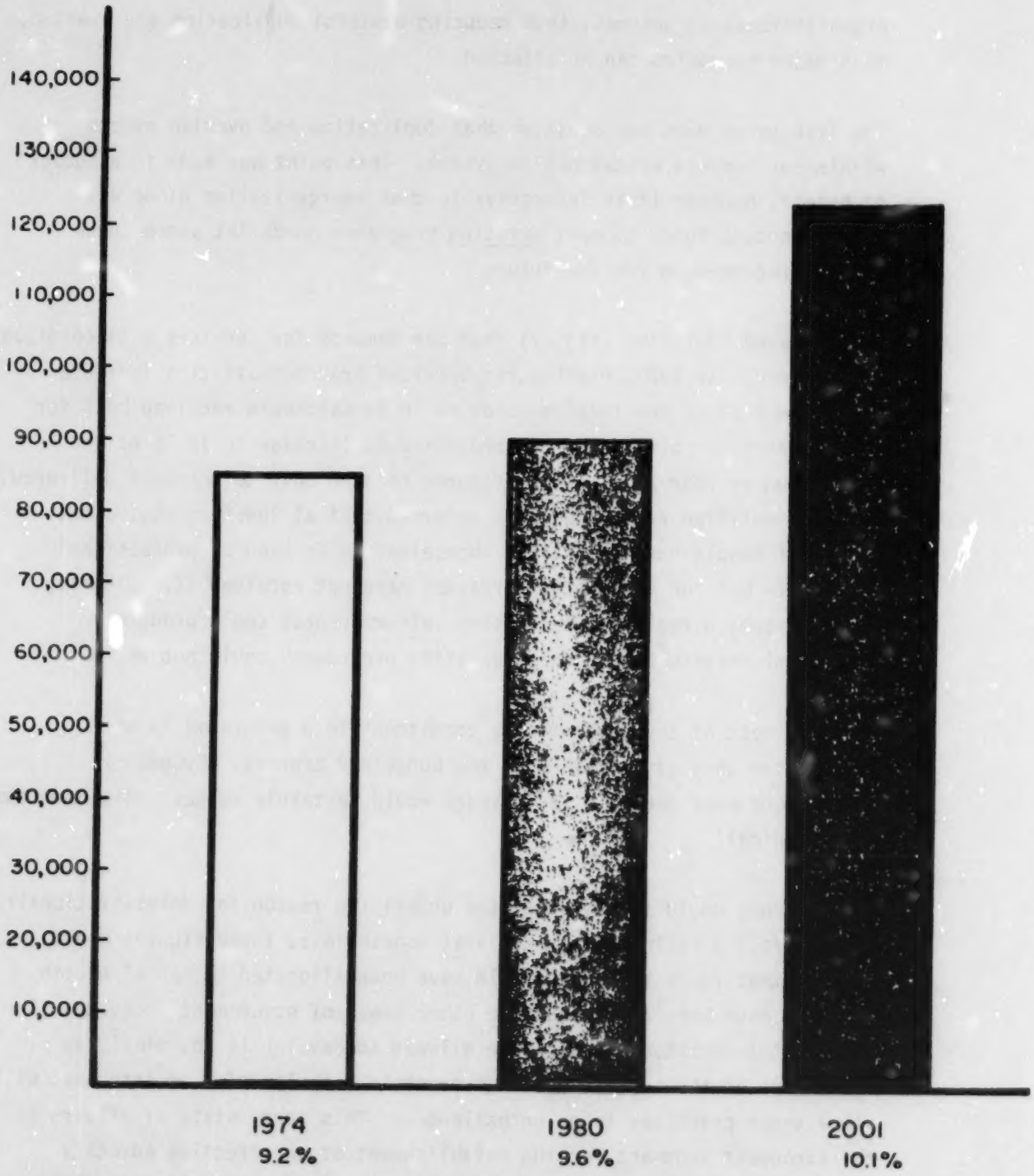
NUMBER OF SASKATCHEWAN RESIDENTS WHO RECEIVE PROFESSIONAL HELP FOR A PSYCHIATRIC PROBLEM EACH YEAR



Source: Adult Working Paper, Task Force on Mental Health in Saskatchewan.

VIII(B) MENTAL HEALTH MANPOWER

The quality of psychiatric treatment is directly dependent upon the staff who conduct the treatment program, their numbers, their training, their experience, and their human qualities.

It was in this area (manpower and personnel) that we found the most serious problem. In our opinion, the Psychiatric Services Branch is in the midst of a personnel crisis. Many staff people have already left the program and others are considering leaving. This problem is most severe with psychiatrists, psychologists and social workers, but it also involves psychiatric nurses and other categories. It should be stressed that Saskatchewan's current hard won psychiatric care program, with emphasis on home placement, depends on a certain irreducible number of field staff to carry out, direct, and supervise the program. If the available staff drops below this number, the whole system will break down, ...

..... Saskatchewan is in a non-competitive position at the present time with regard to salaries, fringe benefits, retirement benefits. permission to do outside work for remuneration, and conditions of work including duty hours. Furthermore, the earlier excitement and stimulation which came from a sense of participation in an innovative, pioneering program is now waning, due partly to a slowdown in the program but due mainly to the fact that other provinces and states are setting up equivalent or better programs.

The foregoing quotation was taken from a document entitled Report of a Consultation to the Minister of Public Health on the Psychiatric Services of Saskatchewan that was submitted by Drs. S. H. Frazier and A. D. Pokorny in 1968 (pp. 26-27). On the basis of numerous submissions to the Task Force, we can only conclude that the situation has not changed in the last fourteen years.

PSYCHIATRISTS:

At the time of the Task Force's Public Hearings, there were 47 fully qualified and licensed psychiatrists working in the province. This figure represents one of the lowest psychiatrist/population ratios in the entire country. It is significantly lower than Ontario, Quebec and British Columbia, and lower than our two neighbouring provinces. The majority of fully qualified licensed psychiatrists in this province work either in the Private Sector or with the University. The remainder work in the Psychiatric Services Branch of the Department of Health.

The majority of physicians employed as psychiatrists by Psychiatric Services Branch are not fully qualified, lacking either the Canadian Specialty qualifications or being ineligible for licensing in this province. Recent changes in the Medical Professions Act make it more difficult for physicians from abroad to acquire a Saskatchewan license. Previous to these changes, physicians who graduated from a number of Commonwealth Universities were entitled to be licensed in Saskatchewan. Because of these arrangements, Saskatchewan has benefited from a steady stream of medical immigrants. The Psychiatric Services Branch, in particular, relied heavily upon them to staff their various programmes. Several submissions to the Task Force pointed out that this was a mixed blessing. While on the one hand these clinicians did fill gaps in the service system, on the other hand they tended to be quite migratory, staying only for brief periods before moving elsewhere in Canada. It would appear that employment with the Provincial Psychiatric Services Branch was frequently used as a means of gaining entrance to Canada and once in, many physicians wasted little time in moving on. This steady turnover in psychiatrists was seen by many as a major obstacle to ensuring continuity of care.

Some briefs addressed the difficulties facing foreign medical graduates who emigrate to Saskatchewan to work in the mental health field. At least two problems were identified: (a) the cultural gap that exists between them and their patients; and, (b) the lack of familiarity with the organization and delivery of mental health services in this province. In an area

of medical practice which is so dependent on the quality of the relationship between the patient and the doctor, it would seem self-evident that we should reduce rather than increase the barriers to good communication. This includes communication between patient and psychiatrist as well as between the psychiatrist and other mental health professionals. Clearly, these problems are not insurmountable; in fact, the Task Force had examples of senior psychiatrists in the province who though from different backgrounds, have successfully made the adjustment and have provided exemplary service.

Having made these observations regarding concerns about the impact of medical immigrants on our mental health system, the Task Force recognizes that many overseas physicians have made significant contributions to the provincial mental health programmes. Unfortunately, many of these skilled clinicians opted not to remain within the service or indeed the province. The Task Force Committee also recognizes the essential role that this group of professionals play in maintaining the present mental health services. Nonetheless, the Committee is concerned about the scarcity of Canadian-born and Saskatchewan-trained psychiatrists, either in the government or in the private sectors of health care.

The Task Force received submissions indicating that the psychiatric manpower crisis exists in all three sectors (Public, Private & University). The Public Sector of Psychiatric Services Branch has continued to experience manpower shortages in spite of Frazier's report of 1968. There would appear to be two major causes of this chronic problem: (1) the actual reduction in total psychiatric positions; and, (2) the continuing high turnover of Branch psychiatrists.

The Annual Reports of Saskatchewan Health reveal that since 1972, there has been a 30% reduction of psychiatrists' positions in the Provincial Psychiatric Service. In 1972, there were 60 positions for psychiatrists; by 1981-82, this had diminished to 42. This reduction coincided with a reported increase in demands for service as well as the identification of an equally large unmet need for services to the young, the elderly and those of Indian ancestry.

A second and equally significant contributory factor to the manpower crisis is the high rate of turnover among Branch psychiatrists. Again, the Annual Reports of the Department of Health in the 1970's consistently report vacancy rates averaging 30%. This reportedly has had serious effects on government programmes. Travelling Clinics have had to be discontinued, while regional psychiatric centres have been threatened with closure due to inadequate numbers of psychiatrist staff. This has forced the government service, on several occasions, to parachute psychiatric consultants into some regions to provide much needed relief to those attempting to maintain at least a minimum service. The Yorkton Psychiatric Centre which won awards for its design, has barely managed to keep afloat over recent years because of serious shortages of psychiatrists.

Job dissatisfaction continues to be the major cause for the high turnover among Branch psychiatrists. It is difficult to retain, let alone attract, psychiatrists to smaller centres such as Yorkton, Weyburn and Swift Current. The high vacancy rates in these centres place unacceptable service pressures on those who do go there. This, plus a sense of professional as well as geographic isolation, makes these practitioners highly vulnerable to job offers elsewhere.

The work situation has not been helped over the past decade by recurring periods of financial constraints which have affected regional programmes; e.g. freezing of vacant positions, cuts in travel budgets, etc. Unfortunately, one of the first items attacked in any budget restraint is the travel budget. Thus, the one measure that effectively combats professional isolation is removed. This simply heightens frustration and resentment. Finally, over the past few years psychiatrists in the Branch have perceived an anti-medical bias both within the Branch and the Department itself.

These work issues, plus the normal problems that their families have in adjusting to a new culture or lifestyle, simply prove too much for many psychiatrists who know that there are more attractive alternatives available elsewhere. It is not surprising then, that over recent years we have lost five psychiatrists to one province which, by its recruiting campaign, made these psychiatrists feel that they would be welcomed.

The Private Sector, unlike its Public counterpart, has remained remarkably stable. In fact, it has shown a modest increase in numbers of the past decade. Saskatchewan, unlike its other Prairie neighbours, has not had a long tradition of Private Psychiatry. Nonetheless, since the development of the Psychiatric Training Programme at the University of Saskatchewan in 1955, a slow but steady stream of graduates has emerged, many of whom have remained in Saskatchewan and many have entered the Private Sector.

Although the smallest of the three sectors, Private Psychiatrists carry a heavy burden of the workload. This is particularly true in the City of Regina where five Private Psychiatrists provide a major portion of extramural and intramural services for the Regina Catchment Area. Although they have managed to maintain a high standard of care, nonetheless they are strained to the limit. The absence of one or two, through illness or vacation, has a significant impact on the entire system. As one brief pointed out, the inability (due to lack of psychiatric manpower) to provide adequate emergency coverage for the psychiatric unit at the major teaching hospital in Regina necessitated its closure. This resulted in the loss of an effective service and teaching programme.

Unlike other areas in Canada, Saskatchewan does not seem to have yet established a mechanism by which private psychiatrists might be recruited. There seems to be no initiative from medical groups, organized clinics or indeed local general hospitals to recruit psychiatrists to staff their psychiatric wards to provide emergency coverage or to meet the other needs of their community hospital. What few recruiting initiatives have been taken have been on an individual basis by one or two of the private psychiatrists.

Saskatoon has benefited by the proximity of the Residency Training Programme at the University of Saskatchewan and thus has the largest number of private psychiatrists. However, as will be described below, this training programme has not been adequate to meet all the needs of Saskatoon let alone those in Regina or elsewhere in the province. Any improvement in the Training Programme in Saskatoon will not benefit Regina until opportunities for

Psychiatric Residency Training are available there. This will only happen when there is a critical mass of teachers in Regina and this will take time. It is apparent, however, that Regina cannot wait for adjustments to the Training Programme in Saskatoon but must take steps to meet the immediate need for more psychiatrists in their catchment area.

The majority of psychiatric specialists practising outside government services are Graduates of the University of Saskatchewan Training Programme. This confirms the findings in other areas of Canada and the United States that graduates tend to practise near their Training Centre. Not only do the Saskatchewan Graduates practise near their Training Centre (that is, within the province), but they tend to remain in Saskatchewan longer. Thus, these graduates are able to provide the continuity that is frequently lacking in programmes staffed by overseas psychiatrists. It would seem, therefore, that the University of Saskatchewan should be looked to as a source of qualified psychiatrists.

A recent external review of the Department of Psychiatry cited that it not only has the smallest faculty but also the fewest number of Residency positions of any academic centre in this country, thus limiting it as a potential source of manpower.

The Department of Psychiatry at University Hospital, housed in cramped quarters and carrying a very heavy service responsibility, attempts to provide specialized services in a number of areas such as Children & Youth, Consultation to the Courts and the Criminal Justice System, Student Health, Home Care and Day/Evening Programmes. It is also called upon to provide service for the majority of psychiatric emergencies within the Saskatoon Catchment Area. In addition to services provided within the Saskatoon region, it is the major referral centre for Northern Saskatchewan. Undermanned as it is, this Department has a third and equally important mandate - to provide teaching to medical undergraduate students. It is hardly surprising then, that External Review bodies have repeatedly questioned the size of the service and teaching responsibilities in proportion to the size of the Department. They have also questioned the viability of a Graduate Training Programme which has positions for only six Residents. This combination of

heavy service load, heavy teaching responsibilities, a small Faculty and few Residents does not project an image that will attract either new faculty or medical graduates. If there is to be a resolution of the psychiatric manpower crisis, it is apparent that we will need more Saskatchewan graduates rather than fewer and to do this we would need a larger programme than that which currently exists.

The Task Force Committee believes that a crisis in psychiatric manpower does exist in Saskatchewan. This situation calls for short- and long-term measures. The short-term measures are directed at attracting qualified Canadian Psychiatrists to practise within the province. The long-term objectives are to improve the training opportunities for graduates of the College of Medicine at University of Saskatchewan in the Specialty of Psychiatry.

In order to attract more medical graduates into this Specialty, more teachers will be required representing more areas and sub-specialties of this growing profession. Emphasis should be placed on the research as well as the teaching and service activities of new recruits. These academic positions should be located primarily in Saskatoon but also in Regina in order to encourage psychiatric Residents to finish their training in Regina and thus increase the potential supply of Consultants for the Southern part of the province. In order to meet these objectives, THE TASK FORCE RECOMMENDS:

90. AN INCREASE IN THE NUMBER OF FULL-TIME AND PART-TIME FACULTY POSITIONS IN THE DEPARTMENT OF PSYCHIATRY IN SASKATOON AND REGINA.

91. THAT A HIGH PRIORITY BE GIVEN TO INCREASING THE NUMBER OF RESIDENCY POSITIONS IN PSYCHIATRY.

92. THE ESTABLISHMENT OF BURSARIES FOR PSYCHIATRIC RESIDENTS TO ENCOURAGE NEW MEDICAL GRADUATES, AND THOSE ALREADY IN PRACTISE, TO ENTER INTO THIS SPECIALTY.

93. THE PROVISION OF TRAVELING FELLOWSHIPS FOR THOSE RESIDENTS IN TRAINING WHO DESIRE SPECIAL TRAINING NOT AVAILABLE IN SASKATCHEWAN.

94. THE DEVELOPMENT OF A VISITING PROFESSOR PROGRAMME TO ENABLE ACKNOWLEDGED NATIONAL AND INTERNATIONAL EXPERTS TO TAKE PART IN RESIDENT EDUCATION AS WELL AS CONTINUING EDUCATION PROGRAMMES FOR THOSE ALREADY IN PRIVATE OR GOVERNMENT PRACTISE.

95. THE ESTABLISHMENT OF RELOCATION GRANTS TO ENCOURAGE ESTABLISHED CANADIAN PSYCHIATRISTS PRACTISING IN OTHER AREAS OF THE COUNTRY TO RELOCATE IN THIS PROVINCE.

96. THAT URGENT ATTENTION BE GIVEN TO THE NEED FOR EXPANSION OF THE PRIVATE SECTOR OF PSYCHIATRY AT REGINA TO MEET THE SERVICE AND TEACHING NEEDS OF THAT REGION.

PSYCHOLOGISTS:

At one time the clinical psychologist's role in our mental health system was restricted to psychometric assessment and/or research. Although psychologists continue to carry out these functions, their role has broadened considerably over the past two decades. The increasingly important role that this professional group plays in the Psychiatric Services Branch is reflected to a degree in the increased size of the number of established positions from 18 in the fiscal year of 1972-73, to 33 in 1980-81.

The Task Force received a joint brief from the Saskatchewan Psychological Association and the Psychological Society of Saskatchewan. This well-documented submission identified a number of concerns relating to manpower. Among these

was a persuasive argument that in spite of the absolute increase in the number of positions for clinical psychology in the provincial government programmes (see above), the Branch lags behind its counterparts in neighbouring provinces. In addition, Saskatchewan has a higher ratio of non-Ph.D. psychologists than comparable programmes in Western Canada. Some mental health professionals in government service alleged that this was due to the deliberate policy of the Public Service Commission to hire at the lowest level of qualification.

Of particular concern to the two Associations was the continually high vacancy rates that exist. This was seen as being destructive of programmes and morale; thus, having both short- and long-term effects. It was suggested that there were four major causes: (a) non-competitive salaries; (b) absence of incentives for professional development; (c) "delays" in filling positions; and, (d) poor morale.

The Psychological Associations alleged that salaries for clinical psychologists in Saskatchewan are not competitive with other provinces, especially in Ontario and British Columbia. This fact, plus the perceived "isolation" of professional life in Saskatchewan makes it extremely difficult to attract qualified professionals to the province and to the Branch. Although the problem of having to sell a career in Saskatchewan to natives of other provinces is not unique to this profession, it is a significant barrier to recruitment. Nonetheless, it is something that can be addressed with appropriate recruiting strategies. No strategy, however, can mask the salary issue.

A feature of any recruiting strategy is the potential for career development. This was another area which psychologists feel Saskatchewan fares badly. There are few incentives within the pay structure of the civil service to encourage professional development. Indeed, all too often the only way a senior and well qualified professional can improve their financial position is by leaving clinical services and going into administration. Thus, at a

time when they have acquired skills and experience that are particularly valuable from a service and/or teaching standpoint, they are "lost" to administration. This issue, again, was not unique to psychologists, being applicable to all professional groups.

An important issue related to professional development was the lack of funding for staff training programmes and for professional travel. It is well known that geographic and professional isolation have significant effects on morale and job satisfaction. This is especially important in a regionalized service programme such as Psychiatric Services Branch. A health programme which is so dependent on the availability of well qualified, highly motivated professionals, is singularly short-sighted to curtail those activities which play such an important role in combating geographic and professional isolation.

The issue, however, that attracted the strongest criticism was that of the delay in filling vacant positions in Branch programmes. Again, this complaint was common to all professional groups. It appeared to be a "system" related rather than a "profession" related problem. The Psychological Associations pointed out the negative impact of these practises on the services programmes as well as the morale of staff. In the opinion of these Associations, as well as other professional bodies, the problem of delayed filling of vacant positions was attributed to inefficiency of the Psychiatric Services Branch's hiring procedures as well as a conscious and deliberate policy of government budget administrators to curtail health costs. While it is inescapable that from time to time during periods of acute financial crisis it may be necessary to put a temporary hold on positions, nonetheless, it would appear to observers of the Saskatchewan Health scene that the "budget freeze" has become part of the management style of the provincial government. It goes without saying that the erratic hiring practises undermine programmes, especially those whose main emphasis is on continuity of care.

A final issue raised by clinical psychologists was that of staff morale.

Although this would seem to be almost inseparable for the three preceding points, nonetheless it warrants separate consideration.

The vast majority of clinical psychologists in Psychiatric Services Branch are in direct service positions. For the most part they are young, well-trained and highly motivated. They are ambitious not only for themselves but for their profession. They are sensitive to the unmet needs that exist in the community and are most desirous of finding alternative methodologies to meet these needs. They are particularly anxious to move into the area of prevention. All in all, they are the type of professional that is needed to provide leadership in the mental health field. A truly comprehensive community-oriented mental health service is dependent upon the existence of such a group. It was distressing, therefore, to the members of the Task Force who heard their submission to learn of the serious morale problems that exists among them. By their own statements they would appear, if not demoralized, at least disheartened.

Like most morale problems, this is multi-determined. A lot of their difficulties are blamed on "administration". They point to what they see as the increasing centralization of decision-making within the Branch and in government itself. Rightly or wrongly, they feel that their opinions are neither sought nor heeded. They feel that the decision-makers are either unaware or insensitive to the problems existing on "the front line". They were particularly incensed at what they saw as the anti-professional bias of the Public Service Commission. They pointed to recent wage negotiations in which they alleged anti-professional criticisms were made by "management". While the Task Force recognizes that in the heat of negotiations intemperate statements may be made, it was obvious that recent negotiations have been especially devisive and that remedial steps will be required if we hope to attract bright young people into these programmes in the future.

If government budgets are a true reflection of government policy, then the policy of the provincial government during the 1970's would appear to have been to limit the development of programmes of the Psychiatric Services Branch. At a time when every other sector of the Department of Health expanded its

activities, the Psychiatric Services Branch appear to be the only area where significant expansion was denied. Indeed, it would not be unfair to say that the 1970's was a period of almost zero growth for the Psychiatric Services Branch. This, of course, had significant implications for programming in that department. There was little opportunity for the development of new or innovative programmes or, indeed, even the expansion of existing programmes. This government policy of budgetary restraint for mental health programmes appears to have had a major effect on morale throughout the Psychiatric Services Branch. It was suggested that this affected the senior bureaucrats as much as it did the front-line professionals; however, it is the front-line professionals that provide the direct service to the community and they are the ones who will implement the programmes. The degree to which they will be able to carry out this function will depend to a large extent on their motivation which, in turn, will depend on their morale. It goes without saying then, that it will be impossible to maintain high morale among ambitious young professionals who are constantly denied the opportunity to use their skills and training. It is policies such as this that contribute to the constant drain of highly trained professionals from this province.

The number of psychologists entering mental health programmes in this province will depend on two sources of supply: (a) graduates of out-of-province programmes; and, (b) graduates of Saskatchewan programmes. Because of the difficulties in recruiting qualified personnel from out-of-province (see above), the most likely source of new recruits will continue to be our two training programmes. Of the two University-based programmes, that of the University of Saskatchewan is the only one to have been accredited by the American Psychological Association; yet even before the drafting of this final report, this programme lost its accreditation because of the lack of sufficient numbers of teaching staff. While not receiving the national recognition of the University of Saskatchewan's programme, the University of Regina's Department of Psychology has nonetheless contributed more graduates to mental health services in this province during recent years.

It is obvious that until our recruiting difficulties are resolved we will be dependent on provincial training programmes to meet our needs for qualified clinical psychologists. It is therefore essential that our students have the opportunity for acquiring a Ph.D. in clinical psychology if we are going to meet the need for well trained clinical personnel.

The Task Force feels that a high priority should be given to training Saskatchewan students in the graduate clinical programme at the University of Saskatchewan (Saskatoon) as well as to the encouragement of the upgrading of psychologists already in the mental health system. To achieve this, THE TASK FORCE RECOMMENDS:

97. THE ESTABLISHMENT OF TRAINING BURSARIES FOR THOSE SASKATCHEWAN STUDENTS ELIGIBLE TO ENTER THE GRADUATE PROGRAMME IN CLINICAL PSYCHOLOGY AT THE UNIVERSITY OF SASKATCHEWAN.

98. THE PROVISION OF TRAINING BURSARIES AND EDUCATIONAL LEAVES FOR PSYCHOLOGISTS AND PSYCHOLOGICAL ASSISTANTS CURRENTLY EMPLOYED BY THE PSYCHIATRIC SERVICES BRANCH TO ENABLE THEM TO UPGRADE THEIR QUALIFICATIONS.

99. THAT THE DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF SASKATCHEWAN, EXPLORE THE POSSIBILITY OF PROVIDING GRADUATE TRAINING TO PART-TIME STUDENTS.

SOCIAL WORK:

Reliable statistics relating to the relative number of social workers in mental health settings in different provinces were not available to the Task Force. On the basis of what information is available, it would appear that the Psychiatric Services Branch employs approximately the same relative number of social workers as is employed by most other provincial mental health departments. As noted earlier, however, a major portion of psychiatric inpatient services is provided in general hospitals and it is in this particular area that Saskatchewan compares unfavourably with its counterparts in Manitoba and Alberta.

As with their psychologist counterparts, the role of social workers in mental health services has expanded over the past two decades. Whereupon at one time their major role was that of a social facilitator (e.g. linking patients and their families up with community agencies, employment, housing, etc.), they have become increasingly involved in treatment programmes and community development. This group has become particularly involved in counselling, outpatient psychotherapy, marital and family therapy, as well as community organization and education.

The Psychiatric Services Branch remains the major employer of social workers involved in mental health activities. This Branch has established positions for approximately 70 social workers; however, high staff turnover has produced a high vacancy rate. Again like their psychological counterparts, social workers find salary levels (particularly for senior workers) lower than those in Alberta and other parts of Canada. They, too, express concern about the lack of pay incentives for professional upgrading and, therefore, the lack of advancement other than through an administrative career. Like other professional groups, social workers complained about poor morale which they attribute mainly to their work situation. This group decried the tendency on the part of government to fill existing vacancies with less well qualified workers. This practise is not consistent with the aspirations of this professional group towards greater, rather than lesser, responsibility in the mental health system which in turn would seem to require more, rather than less, qualified personnel.

The Task Force was informed that due to the lack of a clinically-oriented social work training programme in Saskatchewan, the Psychiatric Services Branch as well as non-government agencies were dependent on the recruitment of graduates from programmes in other parts of Canada. However, because social work salaries within provincial agencies are non-competitive with those in neighbouring provinces, this source of new recruits is in jeopardy. In keeping with our general belief that graduates of training programmes tend to remain in the general region where their training took place, the Task Force would strongly support the development, by the School of Social Work, University of Regina, of programmes specifically designed to equip graduates to work within the developing mental health system. THE TASK FORCE RECOMMENDS:

100. THAT THE UNIVERSITY OF REGINA ESTABLISH A MASTERS PROGRAMME IN SOCIAL WORK WITH A STRONG CLINICAL EMPHASIS.

OCCUPATIONAL THERAPISTS:

A brief from the Saskatchewan Association of Occupational Therapists pointed out the low numbers of this professional group in the province. In addition to recommending the absolute increase in positions available for occupational therapists, this group has recommended the development of a training programme in occupational therapy in the province. Saskatchewan remains one of the few provinces that does not offer a training programme in occupational therapy. This has necessitated Saskatchewan students to train elsewhere with the result that many who could be filling a useful role in our community-oriented mental health programmes are working in other provinces.

Certainly the contribution of occupational therapists to mental health rehabilitation programmes has long been recognized. Saskatchewan has attempted to fill this gap in our comprehensive service programme through the employment of "adjunctive therapists". This group draws upon individuals from a variety of backgrounds to provide rehabilitative services in institutional and

community settings. Given the need for rehabilitation services and the potential benefit large numbers of persons with psychological disabilities can derive from rehabilitative services of good quality, the number of funded positions for occupational therapists is woefully inadequate. Additional positions need to be established not only within the mental health service system but in general and rehabilitative hospitals where one finds the co-existence of both physical and psychological disability.

In the absence of a training programme of its own, the province is dependent on attracting occupational therapy graduates from training programmes in other provinces. No other professional group within the mental health system has had less success in attracting workers to the province. This is due, in part, to the relative scarcity of these professionals as well as the expanded utilization of them in other jurisdictions, particularly Manitoba, Alberta and British Columbia.

It is obvious that occupational therapists like other mental health professionals, have broadened their role in the mental health system. Their clinical activities no longer are hospital based but expand into partial care and community based programmes. It is also obvious that with the aging of our population there will be an increasing need for the skilled assessment and rehabilitation services of this health professional. In view of the above, we agree with the Saskatchewan Association of Occupational Therapists that the resolution of the current manpower problem in occupational therapy requires urgent consideration.

The Saskatchewan Association of Occupational Therapists has put forward to government a proposal for the establishment of a training programme in occupational therapy in this province. While recognizing that this proposal comes at a time of particularly severe fiscal restraint, nonetheless, the need has been well identified and our opinion of their recommendation is well justified. THE TASK FORCE, THEREFORE RECOMMENDS

101. THAT A SCHOOL OF OCCUPATIONAL THERAPY BE ESTABLISHED, PREFERABLY ADJACENT TO OTHER HEALTH CARE EDUCATIONAL PROGRAMMES.

PSYCHIATRIC NURSING:

In Saskatchewan, psychiatric nursing services are provided by three groups of nursing professionals:

(a) Registered Psychiatric Nurses (RPN)
(b) Registered Nurses (RN)
(c) Graduates of College of Nursing, University of Saskatchewan (BScN)

The Registered Psychiatric Nurse is a uniquely Saskatchewan-trained professional. This group was established in Saskatchewan in 1947. It was developed to meet the critical shortage of nurses at a time when RN's were in short supply and when work in the large mental hospitals was not considered an attractive option. A training programme was established in the two mental hospitals and subsequently at the Training School in Moose Jaw. For some time Saskatchewan was the only province that recognized this professional group but they were soon recognized and accepted in other Western provinces as well. Currently the RPN is to be found in programmes of the Psychiatric Services Branch, in general hospital psychiatric units, in provincial correctional services and the Canadian corrections service. It is fair to say they make up the largest group providing psychiatric nursing care in this province.

Initially the mental hospitals served both as training centres and main loci of employment for the RPN. However, with the move from institutional to regionalized services, the RPN's were employed in the new psychiatric units as well as in associated Day Care and Community Mental Health Nursing programmes. In 1973 the responsibility for the training programmes was transferred from the mental hopsitals and the Training School to the Wascana Institute of Applied Arts and Science. The change was more than geographical as it involved a shift from a three-year medically oriented curriculum to a two-year "psychologically oriented" curriculum. The main thrust of the new programme was to prepare nurses for work in the community as opposed to the programmes of the past which were primarily hospital oriented.

A number of submissions raised concerns about the current training programme for RPN's in this province. These concerns related to (a) difficulty

in attr[illegible] sufficient numbers of qualified students; (b) a high attri[illegible]ong those entering the programme; and, (c) whether the prog[illegible]rovided adequate training to enable its graduates to work in gene[illegible] hospital settings.

Another set of concerns came from those who are already a part of the professional group and working in the province. These related to the lack of opportunities for career development. It appeared to many that for a variety of reasons they had a limited future in their profession. In response to this, some expressed the need for a degree programme which would be taken following the RPN which would enable them to assume administrative and teaching roles.

The Task Force learned that the Saskatchewan Registered Psychiatric Nurses Association has put forward a proposal for a Bachelor of Science in Nursing which would be taken under the auspices of the School of Social Work at the University of Regina. While not commenting on the merit of this proposal, the Task Force does consider that this is an indication of the identity crisis that the RPN's are experiencing. The proposal that is mooted would indicate a further shift away from the so-called medical orientation of psychiatric nursing to that of a somewhat undifferentiated community worker. This raises the question as to who will be trained to provide nursing services to those acutely and chronically mentally ill who do require "medical" supervision.

A distressing feature of the psychiatric nursing scene in Saskatchewan has been the long-term rivalry between the Registered Nurses and the Registered Psychiatric Nurses. Historically the origins of this can be readily understood. However, some 35 years have passed since the development of this professional group and currently, although the situation has ameliorated somewhat, there is still wariness on both sides.

The Registered Nurse has been the mainstay of the general hospital system. As the numbers of patients with primary or secondary psychiatric disorders

in general hospital settings has increased, responsibility for providing adequate psychiatric nursing care has fallen on the shoulders of the Registered Nurse. Although most R.N. training courses provide some experience in the nursing management of patients with emotional disorders, many nurses on graduation feel ill prepared to cope with patients with major psychiatric problems. Experience with psychiatric outreach programmes to rural general hospitals indicate that with the assistance of formal inservice training the majority of nurses can acquire sufficient knowledge and skills to enable them to comfortably care for these patients.

The RN's with their basis in medical nursing represent a tremendous potential for the provision of comprehensive nursing services to many patients who present with a combination of physical and emotional difficulties. This is particularly true in urban and tertiary care hospitals where patients in renal dialysis units, emergency departments, intensive care units, burn units, rehabilitation, etc., are often in need of psychological as well as medical nursing care. Unfortunately, in many hospitals the psychological aspects of nursing care are not accorded the same degree of attention as the physical aspects. Clearly there is the need for strong in-service training programmes to remedy this situation.

The College of Nursing at the University of Saskatchewan is responsible for the educational programmes for students who seek the degree of Bachelor of Science Nursing. The Task Force was aware that in recent years there has been criticism of the adequacy of the psychiatric nursing components of the educational programmes. Furthermore, the College's programme has not succeeded in producing a significant number of graduates opting for a career in psychiatric nursing. Recently, however, there are indications that the educational programme has been strengthened, particularly in the area of clinical experience. Concomitant with this has been an increase in a number of students who have identified an interest in the career of psychiatric nursing.

A common complaint of nurses making submissions to the Task Force was the relative lack of inservice and continuing educational programmes. If,

as many would suggest, the general severity of illness of patients in our inpatient settings is increasing then there is a need for nurses with high levels of skill and theoretical knowledge. In order to ensure that these levels are attained and maintained more attention must be given to inservice and continuing education. THE TASK FORCE RECOMMENDS:

102. THAT THE SASKATCHEWAN REGISTERED NURSES ASSOCIATION AND THE SASKATCHEWAN HOSPITAL ASSOCIATION PROMOTE THE DEVELOPMENT OF IN-SERVICE PROGRAMMES ON PSYCHOLOGICAL ASPECTS OF NURSING.

Traditionally, academic centres (e.g. Nursing Schools, Colleges of Medicine, Pharmacy, etc.) have provided the instructors and researchers. It would, therefore, be appropriate to expect the College of Nursing at the University of Saskatchewan to be a major resource. The Task Force learned, however, that because of limited numbers of staff the College of Nursing has not been able to provide these programmes. Furthermore, the lack of appropriate staff has precluded the establishment of a Masters degree programme which would have the potential of providing these professionals. In view of the major part played by the nursing profession in the mental health system in Saskatchewan, it is essential that we ensure that it is of high quality and competitive with comparable programmes across the country. In order to ensure that these objectives are attained, THE TASK FORCE RECOMMENDS:

103. THAT THE COLLEGE OF NURSING AT THE UNIVERSITY OF SASKATCHEWAN DEVELOP A MASTERS DEGREE PROGRAMME IN PSYCHIATRIC NURSING IN ORDER TO PROVIDE THE NECESSARY TEACHERS AND RESEARCHERS REQUIRED TO SUSTAIN A FIRST CLASS NURSING SYSTEM.

104. THAT THE COLLEGE OF NURSING IN CONCERT WITH THE CONTINUING NURSING EDUCATION IN WASCANA INSTITUTE OF APPLIED ARTS AND SCIENCE ESTABLISH PROGRAMMES TO ENABLE QUALIFIED NURSES TO UPDATE AND UPGRADE THEIR PSYCHIATRIC AND MEDICAL NURSING KNOWLEDGE AND SKILLS.

105. THAT THE PROVINCIAL GOVERNMENT THROUGH THE DEPARTMENT OF CONTINUING EDUCATION ESTABLISH BURSARIES TO ENABLE NURSES TO ACQUIRE ADDITIONAL TRAINING IN FIELDS RELATED TO MENTAL HEALTH CARE.

106. THAT THE PSYCHIATRIC SERVICES BRANCH ESTABLISH A SECTION OF INSERVICE NURSING EDUCATION AND ACCEPT THE RESPONSIBILITY FOR DEVELOPING FORMAL INSERVICE EDUCATIONAL PROGRAMMES IN ALL MENTAL HEALTH REGIONS.

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IX FUTURE DIRECTION

The recommendations of the Task Force for future development in mental health programming in Saskatchewan are based on the following beliefs:

1. That health is "a state of complete physical, mental and social well-being and not merely the absence of disease".

2. That every individual has the right to expect an environment which promotes health both physically and psychologically.

3. That every person in Saskatchewan must recognize that they have a role to play in the maintenance of their own and everyone else's mental health.

4. That neither stigma nor blame should be attached to those suffering from mental illness.

5. That every person has the right to expect equivalent care, consideration and acceptance regardless whether they are suffering from a physical or mental illness.

6. That a comprehensive mental health programme should direct itself to prevention as well as to treatment and rehabilitation.

7. That a comprehensive mental health system should:

   (a) be sensitive to the changing mental health needs of the population it serves.

   (b) be accessible to all regardless of age, sex, cultural background or place of residence.

   (c) provide appropriate services for the diverse needs of its individual clients.

   (d) be effective and efficient.

   (e) be accountable to the public it serves as well as its funding agencies.

   (f) be conscious of the need for maximum community involvement in the planning and delivery of mental health services.

RECOMMENDATIONS:

The Task Force recognizes that the effect of years of neglect and discrimination by successive governments has resulted in a system that requires a massive injection of funds to correct its deficiencies. Even in the best of times it would be neither realistic nor possible to correct these shortcomings over night. Nonetheless, it is realistic to expect that governments recognize their responsibility for all constituents, even those who are silent! We also believe it is realistic to expect government to put forward a plan of action to ensure equal treatment for both physical and mental health issues. The Task Force hereby recommends a list of priorities ranked in terms of urgency for the government and the public to consider:

1. FUNDING:

The Task Force feels that the government must recognize the have-not position of mental health services in this province. This situation calls for immediate allocation of a more equitable share of health funds to enable the full implementation of regionalized health programmes, both governmental and non-governmental.

2. MANPOWER:

Mental health professionals are an important natural resource in Saskatchewan. It is essential that our programmes be staffed by the best people available. To redress current shortages, the Task Force recommends that urgent attention be given to those measures that will facilitate the recruitment, retention and training of mental health professionals in Saskatchewan.

3. COMMUNITY RESOURCES:

Mental health and mental health programmes are not just the business of government. They are everyone's business. Accordingly, we recommend that the government give a high priority to developing the latent potential of community resources for the provision of mental health

services ranging from prevention through to rehabilitation. To this end, the government should ensure the provision of funding and consultative services for self-help groups, non-governmental agencies and other community resources to enable the maximum involvement of the community in the planning and provision of mental health services.

4. Mental health services must be flexible in order to adjust to changes in socio-economic pressures, population distribution, available resources and existing knowledge. The government must accept its responsibility to be in the forefront of developments through the promotion of innovative and experimental programmes both governmental and non-governmental.

5. To ensure that the public is receiving effective and efficient services the government should insist that all tax-supported programmes have established standards of care and staffing, and a system for outcome evaluation.

6. The government recognize the need to promote prevention and research as essential components of a comprehensive mental health approach. Funds should be provided for preventive programmes such as public information, education and screening surveys. Furthermore, the research potential in this province should be enhanced by further development of existing governmental programmes in Basic and Applied research.

7. In order to ensure that the proliferation of government and non-government programmes does not result in waste of tax dollars and inadequate service through lack of co-ordination and communication, the government should establish mechanisms in every mental health region to co-ordinate and integrate tax supported mental health programmes.

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X SUMMARY OF RECOMMENDATIONS

CHAPTER IV - EXISTING TREATMENT SERVICES

1. THAT THE GOVERNMENT ESTABLISH A SPECIAL INTERDEPARTMENTAL COMMITTEE TO REVIEW ALL NEW GOVERNMENT ACTIVITIES, POLICIES AND PROGRAMMES WHICH IMPACT ON THE FAMILY.

2. THAT GOVERNMENT PROGRAMMES PROVIDE SUPPORT TO THOSE FAMILIES CARING FOR DISABLED MEMBERS, THROUGH THE PROVISION OF A RANGE OF RESPITE SERVICES INCLUDING DAY CARE, EVENING CARE, AND RESPITE BEDS.

3. THAT SECTIONS 6 AND 7 OF THE FAMILY SERVICES ACT BE IMMEDIATELY IMPLEMENTED.

4. THAT LEGISLATION BE ENACTED TO PROVIDE FINANCIAL SUPPORT TO FAMILIES WHO WISH TO KEEP DISABLED FAMILY MEMBERS AT HOME WHERE THIS IMPOSES A SIGNIFICANT FINANCIAL, PHYSICAL OR EMOTIONAL BURDEN ON THE FAMILY.

5. THAT A HIGH PRIORITY BE GIVEN TO THE DEVELOPMENT OF INNOVATIVE PROGRAMMES DESIGNED TO IMPROVE PUBLIC AWARENESS, UNDERSTANDING AND ACCEPTANCE OF THE MENTALLY ILL AND MENTAL HEALTH PROGRAMMES.

6. THAT THE GOVERNMENT AND PROFESSIONALS RECOGNIZE THE IMPORTANT ROLE OF SELF-HELP GROUPS IN THE OVERALL MENTAL HEALTH SYSTEM AND THAT GREATER EFFORT SHOULD BE MADE TO PROMOTE AND SUPPORT THESE ORGANIZATIONS THROUGH FINANCIAL AND CONSULTATIVE ASSISTANCE.

7. THE MENTAL HEALTH ASSOCIATION MAKE ADVOCACY ITS TOP PRIORITY.

8. THE MENTAL HEALTH ASSOCIATION SIGNIFICANTLY INCREASE ITS EFFORTS IN THE FIELD OF PUBLIC EDUCATION.

9. THAT AN INVENTORY OF ALL HUMAN RESOURCES, GROUPS, AGENCIES, ETC., BE COMPILED FOR EACH REGION. THE RESPONSIBILITY FOR THIS AND ITS CONTINUING UPDATING SHOULD REST WITH THE DEPARTMENT OF SOCIAL SERVICES.

10. THAT STEPS BE TAKEN TO IMPROVE THE UNDERGRADUATE TRAINING OF MEDICAL STUDENTS THROUGH AN INCREASE IN THE TEACHING STAFF AND THE PROVISION OF MORE CLINICAL EXPERIENCE FOR MEDICAL UNDERGRADUATES.

11. THAT THE REQUIREMENTS FOR PRE-REGISTRATION INTERNSHIP TRAINING BE EXPANDED TO INCLUDE A MANDATORY PERIOD OF TRAINING IN A PSYCHIATRIC TEACHING PROGRAMME.

12. THAT THE DEPARTMENT OF PSYCHIATRY IN CONJUNCTION WITH THE DEPARTMENT OF CONTINUING EDUCATION INVESTIGATE METHODS BY WHICH GENERAL PRACTITIONERS COULD BE PROVIDED WITH SHORT, INTENSIVE TRAINING EXPERIENCES THAT WOULD ENABLE THEM TO IMPROVE THEIR PSYCHIATRIC SKILLS.

13. THAT WHERE A GENERAL PRACTITIONER, UPON COMPLETING A RECOGNIZED TRAINING PROGRAMME, DEMONSTRATES COMPETENCE IN A SPECIAL AREA (AS JUDGED BY THE DIRECTOR OF THE TRAINING PROGRAMME) THAT THIS BE RECOGNIZED BY THE MCIC FEE SCHEDULE.

14. THE ESTABLISHMENT IN EACH REGION OF A MENTAL HEALTH ADVISORY COMMITTEE CONTAINING REPRESENTATIVES OF MENTAL HEALTH SPECIALTY SERVICES (PUBLIC AND PRIVATE), COMMUNITY AGENCIES THAT INTERFACE WITH MENTAL HEALTH SYSTEMS, SELF-HELP GROUPS AND THE COMMUNITY AT LARGE.

    THE FUNCTION OF THIS COMMITTEE WOULD BE:

    1) TO PROVIDE ADVICE TO REGIONAL HEALTH, EDUCATION AND SOCIAL SERVICE AGENCIES REGARDING THE ADEQUACY OF EXISTING SERVICES AND THE NEED FOR NEW PROGRAMMES.

    2) TO PROMOTE PROGRAMMES DIRECTED AT ENHANCING THE IMPORTANT SUPPORT ROLES PLAYED BY FAMILIES, NEIGHBOURHOODS, SELF-HELP GROUPS AND INDIGENOUS PROFESSIONALS.

15. THAT THE GOVERNMENT REAFFIRM ITS COMMITMENT TO THE REGIONALIZATION OF MENTAL HEALTH SERVICES TO ENSURE THAT ALL CITIZENS REGARDLESS OF AGE, CULTURAL BACKGROUND OR PLACE OF RESIDENCE HAVE EQUAL ACCESS TO A FULL RANGE OF MENTAL HEALTH PROGRAMMES.

16. TO ENABLE REGIONAL MENTAL HEALTH PROGRAMMES TO PROVIDE THE NECESSARY RANGE OF SERVICES THAT THE GOVERNMENT IMMEDIATELY PROVIDE FINANCIAL AND MANPOWER RESOURCES TO ACHIEVE THIS OBJECTIVE.

17. THAT PSYCHIATRIC SERVICES BRANCH IMMEDIATELY INITIATE PILOT PROJECTS IN URBAN AND RURAL REGIONS TO STUDY ALTERNATIVE MEANS OF MEETING THE UNMET SERVICE NEEDS OF CHILDREN AND YOUTH, THE ELDERLY AND THOSE OF INDIAN ANCESTRY.

18. AN IMMEDIATE REVIEW OF INTRAMURAL SERVICES IN SASKATOON AND REGINA TO IDENTIFY THE NUMBER OF BEDS REQUIRED TO MEET CURRENT AND FUTURE NEEDS OF THE RESIDENTS OF THESE TWO CATCHMENT AREAS.

19. THAT THE PSYCHIATRIC SERVICES BRANCH GIVE TOP PRIORITY TO DEVELOPING AND IMPLEMENTING A PLAN TO MEET THE GROWING PROBLEM OF THE HARD-TO-MANAGE PATIENT IN THE COMMUNITY.

CHAPTER V - COMMUNITY SERVICES

20. THAT THE APPROVED HOME PROGRAMME SHOULD CONTINUE TO PROVIDE THE BACKBONE OF RESIDENTIAL SERVICES IN THE COMMUNITY.

21. THAT APPROVED HOMES BE MAINTAINED AND STRENGTHENED THROUGH IMPROVED SUPERVISION AND MONITORING OF THE QUALITY OF PROGRAMMES WITHIN THE HOMES.

22. THE ESTABLISHMENT OF A MANDATORY TRAINING PROGRAMME FOR ALL PROSPECTIVE APPROVED HOME OPERATORS.

23. THAT URGENT ATTENTION BE GIVEN TO THE NEED FOR ADDITIONAL GROUP HOMES AND SPECIFICALLY THAT THE NUMBER BE INCREASED TO TWENTY WITHIN THE NEXT TWO YEARS.

24. THAT THE MENTAL HEALTH ASSOCIATION IN SASKATCHEWAN IDENTIFY THOSE COMMUNITY LEADERS WHO COULD BE INDUCED TO CO-ORDINATE A COMMUNITY RESPONSE TO THEIR CONTINUING RESIDENTIAL NEEDS, WITH THE EXPECTATION THAT THE PSYCHIATRIC SERVICES BRANCH WOULD ASSIST THESE LEADERS IN THE DEVELOPMENT OF THESE PROGRAMMES.

25. THAT PSYCHIATRIC SERVICES BRANCH ESTABLISH, ON A REGIONAL BASIS, CONTINUING EDUCATION PROGRAMMES FOR SPECIAL CARE HOME OPERATORS AND STAFF.

26. THAT THE DEPARTMENTS OF GERIATRIC MEDICINE AND PSYCHIATRY, OF THE COLLEGE OF MEDICINE, ESTABLISH A GEROPSYCHIATRIC CONSULTATIVE SERVICE AS A DEMONSTRATION PROJECT.

27. THAT THE GOVERNMENT OF SASKATCHEWAN GIVE A TOP PRIORITY TO THE DEVELOPMENT OF A SPECTRUM OF RESIDENTIAL ALTERNATIVES RANGING FROM TEMPORARY TO INDEFINITE RESIDENCES.

28. THAT THE GOVERNMENT OF SASKATCHEWAN PROVIDE GRANTS TO COMMUNITY GROUPS TO ESTABLISH RESIDENTIAL PROJECTS IN BOTH RURAL AND URBAN SETTINGS.

29. THAT A HIGH PRIORITY BE GIVEN TO THE ESTABLISHMENT OF EXPERIMENTAL PROGRAMMES IN VOCATIONAL REHABILITATION TO INCLUDE PRE-VOCATIONAL, VOCATIONAL AND TRANSITIONAL EMPLOYMENT COMPONENTS.

30. THAT GOVERNMENT POLICIES REGARDING COMFORTS ALLOWANCES FOR MENTALLY ILL PATIENTS ON SOCIAL ASSISTANCE BE REVIEWED.

31. THAT A MINIMUM INCREASE OF 25% OF THE CURRENT ALLOWANCE SHOULD BE INITIATED IMMEDIATELY.

CHAPTER VI(A) - THE MENTAL HEALTH OF CHILDREN & YOUTH

32. THAT THE PROVISIONS OF THE UNITED NATIONS DECLARATION OF THE RIGHTS OF THE CHILD BE INCORPORATED INTO SASKATCHEWAN HUMAN RIGHTS LEGISLATION.

33. THAT FUNDS BE PROVIDED TO ENABLE APPROPRIATE COMMUNITY-BASED AGENCIES IN EACH REGION TO COMPILE A COMPREHENSIVE DIRECTOR OF MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH.

34. THAT PSYCHIATRIC SERVICES BRANCH ESTABLISH DEMONSTRATION PROJECTS, TO DETERMINE THE MOST EFFECTIVE AND EFFICIENT WAYS OF PROVIDING SPECIAL MENTAL HEALTH SERVICES TO CHILDREN IN RURAL AREAS.

35. THE IMMEDIATE IMPLEMENTATION OF FAMILY SUPPORT MEASURES PROVIDED FOR IN SECTIONS 6 AND 7 OF THE FAMILY SERVICES ACT OF 1973.

36. THAT THE RECOMMENDATIONS OF THE LAW REFORM COMMISSION OF SASKATCHEWAN REGARDING AGE OF CONSENT FOR HEALTH CARE (INCLUDING COUNSELLING) BE ADOPTED IN SASKATCHEWAN LAW.

37. THAT EQUITABLE FOSTER CARE ALLOWANCES, PROVIDING FOR SUBSTITUTE FOSTER PARENTING, AND REIMBURSEMENT OF ALL HEALTH CARE COSTS, BE PROVIDED BY ALL AGENCIES SUPPORTING FOSTER CARE PROGRAMMES.

38. THAT FUNDING BE PROVIDED TO ESTABLISH INTENSIVE RECREATIONAL PROGRAMMES FOR EMOTIONALLY HANDICAPPED CHILDREN DURING THE SUMMER MONTHS.

39. THAT THE DEPARTMENT OF EDUCATION BE ALLOCATED ADEQUATE FUNDING TO ENABLE IT TO MEET THE DEMANDS FOR PERSONAL COUNSELLING AND MENTAL HEALTH CONSULTATION WITH TEACHERS, DESIGNED TO PROMOTE THE MENTAL HEALTH OF STUDENTS.

40. THAT LEARNING DISABLED AND EMOTIONALLY DISTURBED CHILDREN BE DESIGNATED FOR HIGH COST FUNDING BY REGIONAL PANELS CONSISTING OF MENTAL HEALTH AND EDUCATIONAL PROFESSIONALS WHO SPECIALIZE IN THESE AREAS WITH REPRESENTATION FROM THE CHILDREN'S PARENTS AND TEACHERS.

41. THAT ADDITIONAL FUNDING BE ALLOCATED FOR CHILDREN WHO ARE DESIGNATED LOW COST EMOTIONALLY/BEHAVIOURALLY MALADJUSTED CHILDREN AND THAT SUCH FUNDING BE TIED TO SERVICE DELIVERY.

42. THAT THE DEPARTMENT OF HEALTH ADDRESS THE PROBLEMS OF ADOLESCENT PREGNANCY AND ADOLESCENT SUICIDE THROUGH INCREASED FUNDS FOR PUBLIC EDUCATION, CLINICAL RESEARCH AND SPECIALIZED COUNSELLING SERVICES.

43. THAT THE DEPARTMENT OF HEALTH IDENTIFY AND PROVIDE SPECIALIZED SERVICES TO HIGH-RISK GROUPS SUCH AS HOSPITALIZED CHILDREN AND CHILDREN OF PSYCHIATRIC PATIENTS.

44. THAT THE DEPARTMENT OF HEALTH MAKE MAJOR IMPROVEMENTS IN EARLY DIAGNOSIS AND SCREENING SERVICES AT SPECIFIC DEVELOPMENTAL STAGES OF THE PRESCHOOL AND EARLY SCHOOL YEARS.

45. THAT A FULL RANGE OF OUTPATIENT AND RESIDENTIAL MENTAL HEALTH TREATMENT PROGRAMMES BE MADE AVAILABLE BY THE DEPARTMENT OF HEALTH IN EACH REGION OF THE PROVINCE.

46. THAT THE PSYCHIATRIC SERVICES BRANCH PROVIDE PROJECT FUNDS TO THE MENTAL HEALTH ASSOCIATION TO ESTABLISH A DEMONSTRATION RURAL VOLUNTARY MENTAL HEALTH ACTION GROUP.

CHAPTER VI(B) - THE ELDERLY

47. THAT SENIOR CITIZENS' INCOME LEVELS BE RAISED TO AN ADEQUATE LEVEL EITHER THROUGH ADJUSTMENTS OF THE CANADA PENSION PLAN OR THE IMPLEMENTATION OF A GUARANTEED ANNUAL INCOME.

48. THAT MANDATORY RETIREMENT POLICIES BE REVIEWED AND REVISED TO ENABLE THOSE ELDERLY SO DESIROUS, TO MAINTAIN AS VIGOROUS A WORKING CAREER AS THEY ARE CAPABLE.

49. THE ESTABLISHMENT WITHIN EACH MENTAL HEALTH REGION OF A REGIONAL CO-ORDINATOR FOR SERVICES TO THE ELDERLY. THE FUNCTIONS OF THE CO-ORDINATOR WOULD INCLUDE:
    (A) THE IDENTIFICATION OF COMMUNITY RESOURCES:
    (B) LIAISING WITH HUMAN RESOURCE AGENCIES WHOSE ACTIVITIES INVOLVE THE ELDERLY:
    (C) PUBLIC DISSEMINATION OF INFORMATION RELATING TO AVAILABLE COMMUNITY SERVICES: AND,
    (D) THE IDENTIFICATION OF GAPS IN COMMUNITY PROGRAMMES.

50. GOVERNMENT FUNDING OF COMMUNITY PROGRAMMES SHOULD BE ON THE BASIS THAT THESE PROGRAMMES ARE ACCESSIBLE TO THE ELDERLY.

51. THE PROVISION OF FINANCIAL SUPPORT TO EXTENDED FAMILIES FOR SIGNIFICANT ALTERATIONS TO THE FAMILY RESIDENCE REQUIRED TO ACCOMMODATE THE ELDERLY WITHIN THIS HOME.

52. THE PROVISION IN EACH REGION OF A FULL RANGE OF RESPITE SERVICES FOR THE ELDERLY, INCLUDING SHELTERED DAY CARE, EVENING CARE OR RESPITE BEDS.

53. THAT THE PROVINCIAL AND FEDERAL GOVERNMENTS RECOGNIZE THE NEED TO CORRECT THE NEGATIVE SOCIETAL ATTITUDES TOWARDS AGING AND THE ELDERLY BY MEANS OF A FEDERALLY AND PROVINCIALLY SPONSORED MEDIA CAMPAIGN.

54. THAT THE MINISTER OF HEALTH ESTABLISH A HOSPICE CARE COMMITTEE TO FACILITATE THE INTRODUCTION OF HOSPICES ON A PROVINCE-WIDE BASIS.

55. THE ESTABLISHMENT OF BURSARIES FOR THOSE PROFESSIONALS AND NON-PROFESSIONALS CURRENTLY WORKING WITH THE ELDERLY TO ENABLE THEM TO UPGRADE THEIR KNOWLEDGE AND SKILLS.

56. PROVISION OF ADDITIONAL FUNDS TO THE UNIVERSITIES AND THE VOCATIONAL COLLEGES TO ENABLE THE ESTABLISHMENT OF APPROPRIATE TRAINING PROGRAMMES IN HEALTH CARE FOR THE ELDERLY.

57. THE DEVELOPMENT, ON A REGIONAL BASIS, OF FORMAL INSERVICE TRAINING PROGRAMMES FOR THOSEWHO WORK IN NURSING HOMES, EXTENDED CARE HOMES AND GENERAL HOSPITALS.

CHAPTER VI(C) - INDIAN ANCESTRY

58. THAT THE MAXIMUM FEASIBLE CONTROL OF ALL HEALTH, EDUCATION AND SOCIAL SERVICES PROVIDED TO PERSONS OF INDIAN ANCESTRY (STATUS AND NON-STATUS) BE GIVEN TO THEM BY INVOLVING THEM IN BOTH THE PLANNING AND DELIVERY OF SUCH SERVICES.

59. THAT PERSONS OF INDIAN ANCESTRY BE ASSURED OF ACCESS TO ALL HEALTH, EDUCATIONAL AND SOCIAL SERVICES THROUGH GEOGRAPHIC DECENTRALIZATION AND THE REMOVAL OF CULTURAL AND SOCIO-ECONOMIC DETERRENTS. BAND COUNCILS AND INDIAN ELDERS SHOULD PLAY A SIGNIFICANT ROLE IN PROVIDING LOCAL INPUT REGARDING THE DELIVERY OF SUCH SERVICES.

60. THAT BOTH LEVELS OF GOVERNMENT JOINTLY FUND AN "INDIAN HEALTH, EDUCATION AND SOCIAL NEEDS ASSESSMENT STUDY" DESIGNED AND CONTROLLED BY PERSONS OF INDIAN ANCESTRY IN ORDER TO DETERMINE THEIR NEEDS FOR PSYCHIATRIC AND OTHER SERVICES.

61. THAT PREFERENTIAL HIRING PRACTICES, IN CONJUNCTION WITH AFFIRMATIVE ACTION POLICIES, BE IMPLEMENTED TO ENSURE THAT APPROPRIATE NUMBERS OF PERSONS OF INDIAN ANCESTRY ARE HIRED AND TRAINED TO DELIVER SERVICES TO THE INDIAN ANCESTRY POPULATION. SPECIAL "ON-THE-JOB" TRAINING SHOULD BE PROVIDED TO SUITABLE APPLICANTS AND MORE FLEXIBLE EDUCATIONAL AND EXPERIENTIAL PREREQUISITES SHOULD BE INTRODUCED.

62. THAT ALL PERSONNEL INVOLVED IN THE DELIVERY OF HEALTH AND SOCIAL SERVICES TO PERSONS OF INDIAN ANCESTRY SHOULD RECEIVE APPROPRIATE INSERVICE ORIENTATION AND TRAINING. THIS SHOULD BE GIVEN BY QUALIFIED PERSONS OF INDIAN ANCESTRY IN ORDER TO SENSITIZE MENTAL HEALTH PERSONNEL TO CULTURAL DIFFERENCES AND TO PROVIDE THEM WITH A BETTER UNDERSTANDING OF THE CONFLICTING ATTITUDES, VALUES AND BELIEFS WHICH SOMETIMES NEGATE THE EFFECTIVENESS OF SUCH SERVICES.

63. THAT ONGOING CONSULTATION WITH RELEVANT NATIVE ORGANIZATIONS SUCH AS A.M.N.I.S., F.S.I., THE NATIVE WOMEN'S ORGANIZATION AND FRIENDSHIP CENTRES BE ACTIVELY SOLICITED SO THAT THOSE RESPONSIBLE FOR THE PLANNING AND DELIVERY OF PSYCHIATRIC AND OTHER SERVICES TO PERSONS OF INDIAN ANCESTRY CAN ENSURE CONGRUENCE WITH THE AIMS AND IDEALS OF THE INDIAN PEOPLE AS EXPRESSED THROUGH THEIR ELECTED LEADERS.

64. THAT UNIVERSITIES, TECHNICAL SCHOOLS AND OTHER EDUCATIONAL INSTITUTIONS ENSURE THAT THEIR CURRICULA EMBODIES MATERIAL ABOUT THE NEEDS AND ASPIRATIONS OF THE INDIAN ANCESTRY POPULATION. CURRICULUM PLANNING SHOULD BE UNDERTAKEN IN COLLABORATION WITH PERSONS OF INDIAN ANCESTRY. EDUCATIONAL INSTITUTIONS SHOULD HIRE PERSONS OF INDIAN ANCESTRY TO BE INVOLVED IN THIS AND OTHER EDUCATIONAL PROCESSES IN THE TRAINING OF PROFESSIONALS FOR THE HUMAN SERVICES.

65. THAT FEDERAL DEPARTMENT OF INDIAN AFFAIRS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, IMPROVE THE LEVEL OF SUPPORT FOR ECONOMIC DEVELOPMENT ACTIVITIES ON RESERVES AND IMPROVE SOCIAL, RECREATIONAL, HEALTH AND OTHER HUMAN SERVICES. NO ONE SHOULD BE FORCED TO LEAVE THE RESERVE BECAUSE OF INADEQUATE SERVICES OR OPPORTUNITIES.

66. THAT BOTH LEVELS OF GOVERNMENT, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, ALLOCATE ADEQUATE FUNDS TO PROMOTE INDIAN SOCIAL, CULTURAL AND SPIRITUAL VALUES AND BELIEFS AMONG THE INDIAN ANCESTRY POPULATION. A BROAD BASED EDUCATIONAL PROGRAMME TO EDUCATE THE NON-INDIAN POPULATION ABOUT THE NEEDS AND ASPIRATIONS OF THE INDIAN ANCESTRY POPULATION SHOULD ALSO BE IMPLEMENTED.

67. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, ENSURE THAT HEALTH, EDUCATIONAL, SOCIAL FINANCIAL AND OTHER HUMAN SERVICES ARE MADE AVAILABLE TO ALL PERSONS OF INDIAN ANCESTRY IN A MANNER CONSISTENT WITH THE PROVISION OF SUCH SERVICES TO ALL OTHER MEMBERS OF SOCIETY.

68. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS, IN CONSULTATION WITH PERSONS OF INDIAN ANCESTRY, SHOULD PLAN AND IMPLEMENT A PROGRAMME OF SUPPORT SERVICES FOR PERSONS OF INDIAN ANCESTRY RESIDENT IN URBAN AREAS SO AS TO ENSURE THOSE WHO FREELY CHOOSE TO LIVE IN AN URBAN ENVIRONMENT ARE ASSISTED IN ADJSTING TO THIS ENVIRONMENT IN ALL WAYS POSSIBLE.

69. THAT THE FEDERAL AND PROVINCIAL GOVERNMENTS ACT IMMEDIATELY TO SETTLE OUTSTANDING INDIAN LAND CLAIMS, SINCE THE ECONOMIC STABILITY THAT SUCH A SETTLEMENT WOULD BRING AND THE GOODWILL IT WOULD GENERATE COULD BE EXPECTED TO CONTRIBUTE TO THE IMPROVED MENTAL HEALTH OF THE INDIAN ANCESTRY POPULATION.

CHAPTER VI(D) - WOMEN'S ISSUES

70. THERE SHOULD BE EQUAL PAY FOR EQUAL WORK.

71. SUBSTANTIALLY INCREASED FAMILY ALLOWANCES OR A GUARANTEED INCOME PLAN SHOULD BE INSTITUTED, ALLOWING WOMEN WHO PERFORM THE SERVICES RELATED TO RAISING AND NURTURING CHILDREN TO RECEIVE ADEQUATE REMUNERATIONS.

72. ADDITIONAL FUNDING SHOULD BE ALLOCATED BY THE DEPARTMENT OF HEALTH TO INCREASE VALUABLE PREVENTATIVE MEASURES:

A) BY PROMOTING CONTINUING MEDICAL EDUCATION ON THE EARLY IDENTIFICATION OF HIGH-RISK PREGNANCIES AND THE PROVISION OF APPROPRIATE PRE-, PERI- AND POST-NATAL CARE.

B) THROUGH MEDIA CAMPAIGNS TO PROMOTE WELL ESTABLISHED PREVENTATIVE MEASURES SUCH AS: COMPREHENSIVE VACCINATION, APPROPRIATE NUTRITION, PLANNING FOR PARENTHOOD, SEXUAL EDUCATION AND MONEY MANAGEMENT.

C) ALL WOMEN CONSIDERING ABORTIONS SHOULD HAVE THE RIGHT TO RECEIVE ASSISTANCE FROM THE COUNSELLOR OF THEIR CHOICE.

D) FUNDS SHOULD BE MADE AVAILABLE TO COMMUNITY-BASED ORGANIZATIONS THAT PROVIDE THE SERVICES AS IDENTIFIED IN (B) AND (C) ABOVE.

73. THE SASKATCHEWAN GOVERNMENT SHOULD ESTABLISH AN AUTOMATIC MAINTENANCE ENFORCEMENT PROGRAMME. THE GOVERNMENT OF SASKATCHEWAN SHOULD ASSUME THE RESPONSIBILITY FOR PAYING THE AWARDS WHEN THE EX-SPOUSES DEFAULT IN THEIR PAYMENTS.

74. TRANSITION HOMES SHOULD BE FUNDED ON A PROVINCE-WIDE BASIS TO PROVIDE SHELTER AND RESPITE TO VICTIMS OF SEXUAL OR PHYSICAL ABUSE.

75. EFFORTS SHOULD BE MADE TO ENCOURAGE WOMEN TO ENTER THE MEDICAL PROFESSION TO REFLECT THE GENERAL POPULATION STATISTICS. IN LINE WITH THIS, MEDICAL SCHOOL SELECTION COMMITTEES SHOULD BE SENSITIZED TO THE DESIRABILITY OF RECRUITING WOMEN TO TRAIN AS PHYSICIANS. RESIDENCY AND INTERNSHIP REQUIREMENTS SHOULD BE MADE MORE FLEXIBLE TO ACCOMMODATE FEMALE PHYSICIANS WHO WISH TO PURSUE THE DUAL ROLE OF PROFESSIONAL AND HOMEMAKER.

76. THERE SHOULD BE FUNDS ALLOCATED TO INFORM THE PUBLIC, LEGAL, MEDICAL AND SOCIAL WORK PROFESSION ABOUT THE ISSUES ASSOCIATED WITH RAPE AND PROVIDE ADEQUATE RESOURCES TO DEAL APPROPRIATELY WITH RAPE VICTIMS.

77. A CONCERTED EFFORT SHOULD BE MADE TO RAISE PUBLIC AWARENESS OF THE DANGERS INHERENT IN PORTRAYING NEGATIVE IMAGES OF WOMEN IN THE MEDIA AND THROUGH THE PERPETUATION OF STEROTYPES. THE FOLLOWING ACTIONS SHOULD BE TAKEN:

A) THE C.R.T.C. SHOULD ENFORCE NON-SEXIST POLICIES AS A CONDITION OF GRANTING AND RENEWING LICENSES.

B) AS A PUBLICLY SUPPORTED NETWORK, THE C.B.C. SHOULD BE A LEADER IN PORTRAYING POSITIVE IMAGES OF WOMEN.

C) ALL PROVINCIAL AND FEDERAL ADVERTISING SHOULD PORTRAY POSITIVE IMAGES OF WOMEN AND BROADCAST COUNTER-SEXIST MESSAGES.

CHAPTER VI(E) - MENTAL HEALTH SERVICES FOR THE SPECIAL HANDICAPPED

78. THAT A PILOT PROJECT SHOULD BE ESTABLISHED IN ONE OF THE MAJOR URBAN CENTRES TO DEVELOP PROGRAMMES FOR THE PROVISION OF MENTAL HEALTH CARE TO THE HEARING IMPAIRED.

79. THAT THE SASKATCHEWAN HOSPITAL ASSOCIATION ESTABLISH A TASK FORCE CONSISTING OF REPRESENTATIVES OF MENTAL HEALTH PROFESSIONAL GROUPS AND THE SASKATCHEWAN HOSPITAL SERVICES PLAN TO LOOK AT THE CURRENT AND FUTURE ROLE OF MENTAL HEALTH PROFESSIONALS IN THE GENERAL HOSPITAL SYSTEM.

80. THAT THIS TASK FORCE BE ASKED TO ESTABLISH STAFFING STANDARDS FOR MENTAL HEALTH PROFESSIONALS IN MAJOR MENTAL HOSPITALS.

CHAPTER VI(F) - LAW AND THE MENTALLY DISORDERED

81. THAT AMONG THE VARIOUS HUMAN RESOURCE AGENCIES INVOLVED WITH THE "APPARENTLY MENTALLY DISORDERED" INDIVIDUALS, A MECHANISM BE ESTABLISHED TO IDENTIFY CLEAR POLICIES, PROCEDURES AND ACCOUNTABILITY STRUCTURES.

CHAPTER VI(G) - PERSONS IN GEOGRAPHICALLY ISOLATED AREAS

82. THAT THE SASKATCHEWAN DEPARTMENT OF CONTINUING EDUCATION IN CONJUNCTION WITH PSYCHIATRIC SERVICES BRANCH, ESTABLISH A DEVELOPMENTAL TRAINING PROGRAMME FOR RURAL MENTAL HEALTH PRACTITIONERS.

CHAPTER VII(A) - EDUCATION

83. THAT THE PSYCHIATRIC SERVICES BRANCH ESTABLISH AN EDUCATION AND HEALTH PROMOTION DIVISION TO INCREASE PUBLIC AWARENESS OF MENTAL HEALTH ISSUES AND MENTAL HEALTH PROGRAMMES.

CHAPTER VII(B) - PREVENTION

84. THAT THE GOVERNMENT RECOGNIZE THE IMPORTANCE OF DEVELOPING PRIMARY PREVENTION STRATEGIES IN THE AREA OF MENTAL HEALTH BY PROVIDING SUPPLEMENTARY FUNDING TO ENABLE THE ESTABLISHMENT OF PILOT PROJECTS UNDER THE AEGIS OF BOTH GOVERNMENT AND NON-GOVERNMENTAL AGENCIES.

CHAPTER VII(C) - RESEARCH

85. THAT THE PROVINCIAL GOVERNMENT RECOGNIZE THE IMPORTANT ROLE OF RESEARCH IN A COMPREHENSIVE MENTAL HEALTH SYSTEM AND THAT IT MAINTAIN AND STRENGTHEN ITS SUPPORT OF THE BIOLOGICAL AND APPLIED RESEARCH PROGRAMMES OF ITS PSYCHIATRIC SERVICES BRANCH.

86. THAT THE PSYCHIATRIC SERVICES BRANCH PROMOTE REGIONAL RESEARCH ACTIVITIES THROUGH THE PROVISION OF FUNDING FOR CONSULTATIVE SERVICES AND THE RECOGNITION OF THIS AS A LEGITIMATE PROFESSIONAL ACTIVITY.

CHAPTER VII(D) - EVALUATION OF MENTAL HEALTH SERVICES

87. THAT 3% OF ALL MENTAL HEALTH BUDGETS (GOVERNMENTAL AND NON-GOVERNMENTAL) BE DESIGNATED FOR THE USE OF ESTABLISHING FORMAL EVALUATIVE PROCEDURES.

88. THAT IMPROVEMENT IN THE EVALUATIVE PROCESS BE MADE IN FOUR GENERAL AREAS:

(1) INCREASING THE CAPACITY FOR EVALUATION OF THE SMALL PROGRAMME AND TO INDIVIDUAL WORKER LEVEL;

(2) ESTABLISH THE ROUTINE EVALUATION OF MAJOR PROGRAMMES;

(3) ENSURE THE DEVELOPMENT AND ROUTINE APPLICATION OF QUALITY ASSURANCE MECHANISMS IN ALL PROGRAMMES; AND

(4) TO ENSURE THE MONITORING AND EVALUATION OF THE TOTAL SERVICE DELIVERY SYSTEM ON AN ONGOING BASIS.

CHAPTER VIII(A) - FUNDING

89. THAT GOVERNMENT IMMEDIATELY ALLOCATE AN EQUITABLE SHARE OF HEALTH FUNDS TO THE MENTAL HEALTH PROGRAMMES IN THE PROVINCE.

CHAPTER VIII(B) - MENTAL HEALTH MANPOWER

90. AN INCREASE IN THE NUMBER OF FULL-TIME AND PART-TIME FACULTY POSITIONS IN THE DEPARTMENT OF PSYCHIATRY IN SASKATOON AND REGINA.

91. THAT A HIGH PRIORITY BE GIVEN TO INCREASING THE NUMBER OF RESIDENCY POSITIONS IN PSYCHIATRY.

92. THE ESTABLISHMENT OF BURSARIES FOR PSYCHIATRIC RESIDENTS TO ENCOURAGE NEW MEDICAL GRADUATES, AND THOSE ALREADY IN PRACTISE, TO ENTER INTO THIS SPECIALTY.

93. THE PROVISION OF TRAVELING FELLOWSHIPS FOR THOSE RESIDENTS IN TRAINING WHO DESIRE SPECIAL TRAINING NOT AVAILABLE IN SASKATCHEWAN.

94. THE DEVELOPMENT OF A VISITING PROFESSOR PROGRAMME TO ENABLE ACKNOWLEDGED NATIONAL AND INTERNATIONAL EXPERTS TO TAKE PART IN RESIDENT EDUCATION AS WELL AS CONTINUING EDUCATION PROGRAMMES FOR THOSE ALREADY IN PRIVATE OR GOVERNMENT PRACTISE.

95. THE ESTABLISHMENT OF RELOCATION GRANTS TO ENCOURAGE ESTABLISHED CANADIAN PSYCHIATRISTS PRACTISING IN OTHER AREAS OF THE COUNTRY TO RELOCATE IN THIS PROVINCE.

96. THAT URGENT ATTENTION BE GIVEN TO THE NEED FOR EXPANSION OF THE PRIVATE SECTOR OF PSYCHIATRY AT REGINA TO MEET THE SERVICE AND TEACHING NEEDS OF THAT REGION.

97. THE ESTABLISHMENT OF TRAINING BURSARIES FOR THOSE SASKATCHEWAN STUDENTS ELIGIBLE TO ENTER THE GRADUATE PROGRAMME IN CLINICAL PSYCHOLOGY AT THE UNIVERSITY OF SASKATCHEWAN.

98. THE PROVISION OF TRAINING BURSARIES AND EDUCATIONAL LEAVES FOR PSYCHOLOGISTS AND PSYCHOLOGICAL ASSISTANTS CURRENTLY EMPLOYED BY THE PSYCHIATRIC SERVICES BRANCH TO ENABLE THEM TO UPGRADE THEIR QUALIFICATIONS.

99. THAT THE DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF SASKATCHEWAN, EXPLORE THE POSSIBILITY OF PROVIDING GRADUATE TRAINING TO PART-TIME STUDENTS.

100. THAT THE UNIVERSITY OF REGINA ESTABLISH A MASTERS PROGRAMME IN SOCIAL WORK WITH A STRONG CLINICAL EMPHASIS.

101. THAT A SCHOOL OF OCCUPATIONAL THERAPY BE ESTABLISHED, PREFERABLY ADJACENT TO OTHER HEALTH CARE EDUCATIONAL PROGRAMMES.

102. THAT THE SASKATCHEWAN REGISTERED NURSES ASSOCIATION AND THE SASKATCHEWAN HOSPITAL ASSOCIATION PROMOTE THE DEVELOPMENT OF IN-SERVICE PROGRAMMES ON PSYCHOLOGICAL ASPECTS OF NURSING.

103. THAT THE COLLEGE OF NURSING AT THE UNIVERSITY OF SASKATCHEWAN DEVELOP A MASTERS DEGREE PROGRAMME IN PSYCHIATRIC NURSING IN ORDER TO PROVIDE THE NECESSARY TEACHERS AND RESEARCHERS REQUIRED TO SUSTAIN A FIRST CLASS NURSING SYSTEM.

104. THAT THE COLLEGE OF NURSING IN CONCERT WITH THE CONTINUING NURSING EDUCATION IN WASCANA INSTITUTE OF APPLIED ARTS AND SCIENCES ESTABLISH PROGRAMMES TO ENABLE QUALIFIED NURSES TO SUPDATE AND UPGRADE THEIR PSYCHIATRIC AND MEDICAL NURSING KNOWLEDGE AND SKILLS.

105. THAT THE PROVINCIAL GOVERNMENT THROUGH THE DEPARTMENT OF CONTINUING EDUCATION ESTABLISH BURSARIES TO ENABLE NURSES TO ACQUIRE ADDITIONAL TRAINING IN FIELDS RELATED TO MENTAL HEALTH CARE.

106. THAT THE PSYCHIATRIC SERVICES BRANCH ESTABLISH A SECTION OF INSERVICE NURSING EDUCATION AND ACCEPT THE RESPONSIBILITY FOR DEVELOPING FORMAL INSERVICE EDUCATIONAL PROGRAMMES IN ALL MENTAL HEALTH REGIONS.

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XI MEMBERS OF THE TASK FORCE

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**Replaced by Mr. Paul Grocott on October 1, 1982.